

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031291

FILED VS AUG 25 1959 60

6225

139

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY Vernon				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Township		Length of stay in 1b 3yrs 2 mos		c. CITY OR TOWN Webb City		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No. 3			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Route #1		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Harvey Middle Andrew Last Ladd				4. DATE OF DEATH Month August Day 14 Year 1959					
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1-24-83	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Jasper County, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Charles Ladd			13b. MOTHER'S MAIDEN NAME Delilah G. Good			14. NAME OF HUSBAND OR WIFE Lettie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Records-State Hospital #3, Nevada, Mo.					
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Generalized Atherosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 1 Week Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) -----						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) -----					
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		-----							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -----		20f. CITY, TOWN, OR LOCATION -----		COUNTY -----		STATE -----	
21. I attended the deceased from 6-6-56 to 8-14-59 and last saw him alive on 8-14-59 Death occurred at 11:05 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>W. C. Bradley M.D.</i> (Degree or title)				22b. ADDRESS <i>State Hospital #3, Nevada, Mo</i>				22c. DATE SIGNED 8-14-59 (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8/14/59	23c. NAME OF CEMETERY OR CREMATORY FREASANT Hill		23d. LOCATION (City, town, or county) JASPER Co., Mo.				
24. FUNERAL DIRECTOR Johnson, Arnce, Simpson, Webb City				25. DATE RECD. BY LOCAL REG. 8-21-1959		26. REGISTRAR'S SIGNATURE <i>Arma & Jerry</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lloyd C. McLeod

Licensed Embalmer No. 4855

P. O. Address Monday, 7/7

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.