

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031293

FILLED VS AUG 25 1959 360

Registration District No. _____ Primary Registration District No. 6225 Registrar's No. 135

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Barton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Nevada</u>		Length of stay in 1b <u>10 mo 2 days</u>	c. CITY OR TOWN <u>Irwin</u> Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #3</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>_____</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ruby</u> Middle <u>D. Lavery</u> Last <u>Lipscomb</u>			4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1, 1893</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>16</u> Hours <u>_____</u> Min. <u>_____</u>	IF UNDER 24 HR Hours <u>_____</u> Min. <u>_____</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>_____</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Leonard Lavery</u>		13b. MOTHER'S MAIDEN NAME <u>Daisy Hay</u>		14. NAME OF HUSBAND OR WIFE <u>A.L. Lipscomb</u>			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT <u>Hospital records - Nevada, Mo</u> Address _____
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Bronchial</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
DUE TO (b) <u>Gen Arterio Sclerosis</u>		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Euchemia</u>		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 checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>_____</u>
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		

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.) <u>_____</u>	20f. CITY, TOWN, OR LOCATION <u>_____</u>	COUNTY <u>_____</u>	STATE <u>_____</u>
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21. I attended the deceased from Oct 14, 1958 to Aug 16, 1959 and last saw her alive on Aug 16, 1959.
Death occurred at 7:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W. C. Bradburn</u> (Degree or title)		22b. ADDRESS <u>State Hospital #3, Nevada, Mo</u>		22c. DATE SIGNED <u>8-16-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug 18 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Park</u>	23d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>	
24. FUNERAL DIRECTOR <u>Konantz Funeral Home, Lamar, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-18-1959</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Ferry</u>	

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 Carl F. Konantz

Licensed Embalmer No. 2247

P. O. Address Lamar, Mo.

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.