

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 28 1959

59-031345

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 3000 Registrar's No. 291

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wolcott</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived; if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Rockville</u>	Length of stay in lb OR TOWN <u>3 weeks</u>	c. CITY OR TOWN <u>Wentz</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Truett Hosp</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) ---	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print) First <u>THOMAS</u> Middle <u>McKINRA</u> Last <u>LIKE</u>			<b>4. DATE OF DEATH</b> Month <u>Sept</u> Day <u>23</u> Year <u>1959</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>12-10-1883</u>	<b>9. AGE</b> (last birthday) <u>75</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Monument Maker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Monument Makers</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>St. Louis, Mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	
<b>13a. FATHER'S NAME</b> <u>Wm. Like</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Agnes M. Priddy</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Wm. Like</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
<b>16. SOCIAL SECURITY NO.</b> ---		<b>17. INFORMANT</b> <u>Wm. Lyberk Like</u>		Address <u>Wentz</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	

IMMEDIATE CAUSE (a) <u>Septic Pneumonia</u> (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Arteriosclerotic Vascular Disease</u>	INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>  <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetic Mellitus</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	

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.		Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	COUNTY _____	STATE _____

21. I attended the deceased from August 28 1959 to Sept 23 1959 and last saw him alive on Sept 23 1959  
 Death occurred at 8:30 pm on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>Wm. Lyberk Like MD</u>		<b>22b. ADDRESS</b> <u>711 W. Jefferson Kirkville</u>		<b>22c. DATE SIGNED</b> <u>9/25/59</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>Sept. 26 59</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Truett Cemetery</u>	<b>23d. LOCATION</b> (City, town, or county) <u>Wentz, Missouri</u>		
<b>24. FUNERAL DIRECTOR</b> <u>Wm. Lyberk Like</u>		ADDRESS ---		<b>25. DATE RECD. BY LOCAL REG.</b> <u>9-25-1959</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Wm. W. Ruff</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

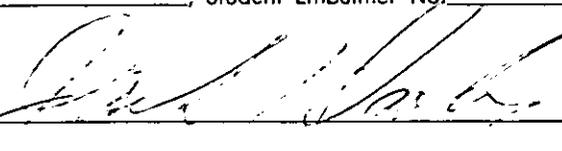
MS 67-19 1959

BETTY H. SLAUGHTER, D.O.

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 

Licensed Embalmer No. 4619  
P. O. Address \_\_\_\_\_

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.

OCT 6 1959