RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 6 1959

59–031783
STATE FILE NUMBER

Registration District No. 71 Primary Registration District No. 3013 Registrar's No. 88

DOCUMENT

1. PLACE OF DEATH
a. COUNTY: CLAY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: EXCELSIOR SPRINGS — Length of stay in 1b: 3 DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: LAKE MAURER — Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: WORTH
c. CITY OR TOWN: GRANT CITY — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): NONE — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First JUANITA Middle P. Last DICKEY
4. DATE OF DEATH: Month SEPT. Day 14 Year 1959
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6-6-1916
9. AGE (last birthday): 43
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (City and state or country): WORTH Co., MO.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: MICHAEL FLETCHALL
13b. MOTHER'S MAIDEN NAME: ZELLA GATES
14. NAME OF HUSBAND OR WIFE: RAYMOND DICKEY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: YES, UNK.
17. INFORMANT: RAYMOND DICKEY Address: GRANT CITY, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Unknown (Probable Acute Coronary)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
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. ☐ Yes ☐ No ☐ Unknown

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

BY AFFIDAVIT OF

21. I attended the deceased from ____, to ____ and last saw her/him alive on ____
Death occurred at ____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: D. L. Pain M.D. (Degree or title) Coroner
22b. ADDRESS: North Kansas City Mo
22c. DATE SIGNED: 9/16/59
23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: 9-14-59
23c. NAME OF CEMETERY OR CREMATORY: UNKNOWN
23d. LOCATION (City, town, or county) (State): GRANT CITY, MO.
24. FUNERAL DIRECTOR: Prichard Funeral Home, Inc. ADDRESS: Excelsior Springs, Missouri
25. DATE RECD. BY LOCAL REG.: 9/26/59
26. REGISTRAR'S SIGNATURE: Caroline Hutchings

(Licensed Embalmer's Statement on Reverse Side)

MAY 8 1960

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 Lindell James

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.