

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS SEP 22 1959

59-031864

Registration District No. 93 Primary Registration District No. _____ Registrar's No. 59-73 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Dade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lockwood Mo</u>		Length of stay in 1b <u> yrs</u>		c. CITY OR TOWN <u>Lockwood Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Lockwood</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>May</u> Last <u>Peer</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>9</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 18, 1879</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>21</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>House Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Lawrence Co Mo</u>		11. BIRTHPLACE (City and state or country) <u>usa</u>		12. CITIZEN OF WHAT COUNTRY <u>usa</u>		
13a. FATHER'S NAME <u>Milton Connell</u>			13b. MOTHER'S MAIDEN NAME <u>Unkown</u>			14. NAME OF HUSBAND OR WIFE <u>Eula Alverson Lockwood Mo</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>none</u>		17. INFORMANT <u>Eula Alverson Lockwood Mo</u>				Address	
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>Cerebral Vascular Accident</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>							<u>year</u>		
DUE TO (c) <u>Hypertension</u>							<u>year.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension, Chronic Cholelithiasis, Colon Diverticulitis</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 _____ 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.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>7-23-58</u> to <u>9-9-59</u> and last saw her alive on <u>9-9-59</u> . Death occurred at <u>8:00P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Emer W. Taylor M.D.</u>				22b. ADDRESS <u>807 main St Lockwood Mo</u>			22c. DATE SIGNED <u>9/11/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Sept. 12 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lockwood</u>		23d. LOCATION (City, town, or county) (State) <u>Lockwood Mo</u>				
24. FUNERAL DIRECTOR <u>Allison Funeral Home Greenfield M.</u>				25. DATE RECD BY LOCAL REG. <u>9/14/1959</u>		26. REGISTRAR'S SIGNATURE <u>J. C. Canada</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 W. R. Allison

Licensed Embalmer No. 440

P. O. Address Greenfield

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.