URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS NOV 12 1959

59-035549

STATE FILE NUMBER

MENDED

Registration District No. 73 Primary Registration District No. 5291 Registrar's No. 124

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY Clay
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Liberty — Length of stay in 1b: 2 years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 304 Bonnie Lane Glenaire — Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Clay
c. CITY OR TOWN Liberty — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 304 Bonnie Lane Glenaire — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Alec — Middle Loren — Last Locker

4. DATE OF DEATH: Month October — Day 31, — Year 1959

5. SEX: male

6. COLOR OR RACE: white

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 4-22-16

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): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Associated Transport

11. BIRTHPLACE (City and state or country): Sheldon, Mo.

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Lloyd A. Locker

13b. MOTHER'S MAIDEN NAME: Alta Simpson

14. NAME OF HUSBAND OR WIFE: Anna Cauthan Locker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 497-14-3686

17. INFORMANT: Anna C. Locker — Address: Liberty, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Carcinoma Varis (generalized) | 1 yr. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) | Carcinoma of Colon | 3 years |
| DUE TO (c) | | |

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

21. I attended the deceased from 1956 to 10-21-59 and last saw him alive on 10/6/59

Death occurred at 1:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: O A Kienberger (Degree or title) MD

22b. ADDRESS: 5246 St John K.C. Mo

22c. DATE SIGNED: 11/2/59

23a. BURIAL, CREMATION, REMOVAL (Specify): removal

23b. DATE: 11-3-59

23c. NAME OF CEMETERY OR CREMATORY: Osceola Cemetery

23d. LOCATION (City, town, or county) (State): Osceola, Missouri

24. FUNERAL DIRECTOR: Tyler-Pasley — ADDRESS: Liberty, Mo.

25. DATE RECD. BY LOCAL REG.: 11-7-59

26. REGISTRAR'S SIGNATURE: Mabel Graham

(Licensed Embalmer's Statement on Reverse Side)

**STATEMENT BY LICENSED EMBALMER** JAN 4 1960

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed Charles T. Taylor
Signature of Student Embalmer

Licensed Embalmer No. 4534

P. O. Address Liberty M

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