

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS OCT 26 1959 *382*

*4230*

*19*

**59-036015**

STATE FILE NUMBER

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

UNDECEASED

1. PLACE OF DEATH a. COUNTY <b>Howard</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Howard</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Armstrong</b>		Length of stay in 1b <b>61 yrs.</b>		c. CITY OR TOWN <b>Armstrong</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bagby Drug Store</b>			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 checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Walker</b> Last <b>Lenoir</b>				4. DATE OF DEATH Month <b>October</b> Day <b>13</b> Year <b>1959</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 26, 1874</b>		9. AGE (last birthday) <b>85</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		11. BIRTHPLACE (City and state or country) <b>Columbia, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13a. FATHER'S NAME <b>Dr. W. T. Lenoir</b>			13b. MOTHER'S MAIDEN NAME <b>Nancy Walker</b>			14. NAME OF HUSBAND OR WIFE <b>Lucretia Denny</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John Denny, Boonville, Missouri</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion -</b> DUE TO (b) <b>Arteriosclerosis -</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>	
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. <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 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 <b>1958</b> to <b>10/13/59</b> and last saw her/him alive on <b>10/13/59</b> Death occurred at <b>7:15 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>M. P. Reuch M.D.</b> (Degree or title)					22b. ADDRESS <b>Fayette, Mo</b>			22c. DATE SIGNED <b>10/14/59</b> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 16, 59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Walnut Ridge Cem.</b>		23d. LOCATION (City, town, or county) <b>Armstrong, Missouri</b>			
24. FUNERAL DIRECTOR <b>Markland - Hall New Franklin, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>10/14/59</b>		26. REGISTRAR'S SIGNATURE <b>Walker Audaley</b>			

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Tom D. Markland

Licensed Embalmer No. 4592

P. O. Address New Franklin

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.