

# URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039478

FILED VS NOV 25 1959

STATE FILE NUMBER

Registration District No. 93 Primary Registration District No. \_\_\_\_\_ Registrar's No. 59-25

ENDED

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 lb <u>yrs</u>		c. CITY OR TOWN <u>Lockwood Mo</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>Memorial Hospital</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 checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Gerna</u> Middle <u>Barclay</u> Last _____				4. DATE OF DEATH Month <u>Nov</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29, 1875</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>10</u>		IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Ancon C Barclay</u>			13b. MOTHER'S MAIDEN NAME <u>Phronia Kitrell</u>			14. NAME OF HUSBAND OR WIFE	
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>Louzetta Preston Lockwood</u> Address <u>Mo rt</u>			
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>Coronary occlusion</u> <u>Cachexia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Small bowel Volvulus &amp; resection</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u> <u>1 mo.</u> <u>6 weeks.</u>	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>7-22-59.</u> to <u>11-9-59</u> and last saw him alive on <u>11-9-59</u> Death occurred at <u>10:10p</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Elmer W. Taylor M.D.</u> (Degree or title)				22b. ADDRESS <u>807 main st Lockwood, Mo</u>		22c. DATE SIGNED <u>11/13/59.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov 11 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedarville</u>		23d. LOCATION (City, town, or county) (State) <u>Dade Co Mo</u>	
24. FUNERAL DIRECTOR <u>Allison Funeral Home Greenfield Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>11/18/1959</u>		26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 W. R. Allison

Licensed Embalmer No. 4404

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.