

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 29 1959

'59 0 4 4 6 4 1

STATE FILE NUMBER

Registration District No. 175 Primary Registration District No. 3036 Registrar's No. 127

ENDED

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|--|--|---|--|---|--|--|---|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Lawrence | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Lawrence | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Aurora | | Length of stay in 1b Years | | c. CITY OR TOWN Aurora | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Aurora Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 925 Porter | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First LUCY Middle LEOLA Last LARSON | | | | 4. DATE OF DEATH Month December Day 20 Year 1959 | | | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 10/17/96 | | 9. AGE (last birthday) 63 | | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (City and state or country) Lawrence Co., Mo. | | | 12. CITIZEN OF WHAT COUNTRY USA | | | | | |
| 13a. FATHER'S NAME James Berry | | | 13b. MOTHER'S MAIDEN NAME Ellen Berry | | | 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) No | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Vera Sheldon; Aurora, Mo. | | | | | | | | |
| 18. CAUSE OF DEATH. (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 hour | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | | | | | 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 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 7/1/58 to 12/20/59 and last saw ^{her} him alive on 12/20/59 Death occurred at 8:25 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE J.D. Morrison M.D. | | | | 22b. ADDRESS Aurora Mo. | | | | 22c. DATE SIGNED 12/21/59 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12/23/59 | | 23c. NAME OF CEMETERY OR CREMATORY Maple Park Cemetery | | | 23d. LOCATION (City, town, or county) (State) Aurora Mo. | | | | | | |
| 24. FUNERAL DIRECTOR Arnold Funeral Home; Aurora, Mo. | | | | 25. DATE RECD. BY LOCAL REG. 12/23/59 | | 26. REGISTRAR'S SIGNATURE Dora Mc Natt | | | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 14 1960

STATEMENT BY LICENSED EMBALMER

DEC 2

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 Irvin R. Arnold

Licensed Embalmer No. 4929

P. O. Address Aurora, Mo.

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