

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 44728

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Registration District No. \_\_\_\_\_ Primary Registration District No. 7041 Registrar's No. 219

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>Macon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Macon</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Macon</b>		c. CITY OR TOWN <b>Macon</b>	
Length of stay in 1b		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>Samaritan</b>		d. STREET ADDRESS (If outside, give location) <b>129 Goggin</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>ELSIE</b> Middle <b>FLORENCE</b> Last <b>LUCAS</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>24</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/1/1893</b>	9. AGE (last birthday) <b>66</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Macon Co. Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>R.T. Peterson</b>			13b. MOTHER'S MAIDEN NAME <b>Ida Florence Bowen</b>			14. NAME OF HUSBAND OR WIFE <b>S.W. Lucas</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>S.W. Lucas</b>		Address <b>Macon, Missouri</b>	
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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) <b>Coronary Heart Failure</b>			<b>48 hrs</b>	
DUE TO (b) <b>Arteriosclerotic Cardiovascular disease</b>			<b>10 yrs</b>	
DUE TO (c) <b>Phenylac Heart disease, Old</b>			<b>50 yrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				

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		
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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	
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21. I attended the deceased from **Dec 22** and last saw her alive on **Dec 24**  
Death occurred at **3:20 am** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>James E. Campbell MD</b> (Degree or title)			22b. ADDRESS <b>Macon Mo.</b>			22c. DATE SIGNED <b>12/28/59</b> (State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/26/1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Salem</b>		23d. LOCATION (City, town, or county) <b>Excello, Missouri</b>			

24. GENERAL DIRECTOR <b>R. Lester Bram</b> ADDRESS <b>Macon, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>12/30/59</b>		26. REGISTRAR'S SIGNATURE <b>Ruth M. Uccely</b>			
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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 R. J. Bran

Licensed Embalmer No. 4472

P. O. Address Macon, Ga.

**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.