

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. DEC 28 1959 378

Registration District No. 4552 Primary Registration District No. 45 Registrar's No. 45

59 046640 STATE FILE NUMBER

ENDE

1. PLACE OF DEATH a. COUNTY <u>Wright</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wright</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mountain Grove</u>		Length of stay in 1b		c. CITY OR TOWN <u>Mountain Grove</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>South Side</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>South Side</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Norma</u> Middle <u>Anne</u> Last <u>LeMond</u>				4. DATE OF DEATH Month <u>December</u> Day <u>9</u> Year <u>1959</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8-11-1931</u>	9. AGE (last birthday) <u>28</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Mountain Grove, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Leroy Brown</u>			13b. MOTHER'S MAIDEN NAME <u>Kathleen Davidson</u>			14. NAME OF HUSBAND OR WIFE <u>David LeMond</u>			
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>497-30-4436</u>		17. INFORMANT Address <u>David LeMond Mtn Grove, Missouri</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 Thrombosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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. <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 <u>3-2-59</u> to <u>12-9-59</u> and last saw her <u>him</u> alive on <u>3-2-59</u> . Death occurred at <u>5:10 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>W. A. Craig DO</u> (Degree or title)				22b. ADDRESS <u>Mountain Grove Mo</u>				22c. DATE SIGNED <u>12-11-59</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-11-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		23d. LOCATION (City, town, or county) <u>Mtn Grove, Missouri</u>					
24. FUNERAL DIRECTOR ADDRESS <u>Ewell C. Craig Mtn Grove, Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>12-14-1959</u>		26. REGISTRAR'S SIGNATURE <u>Bernice R. Seberman</u>			

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Lewell C. Carney*

Licensed Embalmer No. 476

P. O. Address *Mtn. Grove*

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.