

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000349

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Buchanan</i>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Length of stay in 1b <i>60 years</i>		c. CITY OR TOWN <i>St. Joseph</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>6505 Washington St.</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>6505 Washington St.</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>Deliska</i> Middle _____ Last <i>Lawhon</i>				4. DATE OF DEATH Month <i>January</i> Day <i>29</i> Year <i>1960</i>					
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 28, 1884</i>	9. AGE (last birthday) <i>75</i>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Our home</i>		11. BIRTHPLACE (City and state or country) <i>Princeton County, Mo.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		
13a. FATHER'S NAME <i>George Knowles</i>			13b. MOTHER'S MAIDEN NAME <i>Donna Snow</i>		14. NAME OF HUSBAND OR WIFE <i>Clarence D. Lawhon</i>			Address _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Clarence D. Lawhon</i>			Address <i>6505 Washington St.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema due to Hypertension</i>							INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerosis of heart & vessels</i>									
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 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 <i>Jan 3, 1959</i> to <i>Jan 29, 1960</i> and last saw her alive on <i>January 29, 1960</i> Death occurred at <i>7:15 p</i> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>Martin of Christ MD</i>				22b. ADDRESS <i>6106 King Hill Ave St Joseph</i>			22c. DATE SIGNED <i>2-1-60</i>		
23a. BURIAL (CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Feb. 1, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Joseph, Mo.</i>				
24. FUNERAL DIRECTOR <i>Clark Funeral Home St. Joseph, Mo.</i>				25. DATE RECD. BY LOCAL REG. <i>Feb. 2, 1960</i>		26. REGISTRAR'S SIGNATURE <i>Wm. Clark Goodell</i>			

DOCUMENT

BY AFFIDAVIT OF

M.H. Christ, M.D. MEDICAL CERTIFICATION

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 *Emma Clark*

Licensed Embalmer No. 4238

P. O. Address *St. George*

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.