

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005994

FILED VS MAR 7 1960

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 34

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Daviess</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bethany</u>		Length of stay in 1b		c. CITY OR TOWN <u>Pattersonburg</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>Lacy Rest Home</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>CLARA</u> Middle <u>WELDEN</u> Last <u>DAVIESS</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 1870</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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 <u>Housewife</u>		11. BIRTHPLACE (City and state or country) <u>DAVIESS</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Joseph Meadows</u>			13b. MOTHER'S MAIDEN NAME <u>Mary EBERIE</u>		14. NAME OF HUSBAND OR WIFE <u>Richard Welden</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>NO.</u>		17. INFORMANT Address <u>Mollie Waize Pattersonburg Mo.</u>			
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) <u>Broncho-Pneumonia</u>						<u>2 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>Influenza</u> <u>7 days</u>	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Advanced Senility</u>					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 <u> </u> s.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>							
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>11-11-59</u> , to <u>2-21-60</u> and last saw her ^{live} _{die} on <u>2-21-60</u> Death occurred at <u>6:30 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>G.M. Morgan</u> (Degree or title)				22b. ADDRESS <u>D.O. Bethany, Mo.</u>		22c. DATE SIGNED <u>2-22-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>23 Feb 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I. O. O. F.</u>		23d. LOCATION (City, town, or county) (State) <u>Pattersonburg Mo.</u>		
24. FUNERAL DIRECTOR <u>H.A. Roberson</u>		ADDRESS <u>Pattersonburg Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-29-1960</u>	26. REGISTRAR'S SIGNATURE <u>Jella Maxey</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 10 1960

AUG 18 1960

AUG 24 1960

OCT 18 1960

JAN 20 1961

SEP 23 1960

APR 4 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____

or by _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *W. H. Robinson*

Licensed Embalmer No. 5075

P.O. Address *Patrolman*

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.