

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006993

FILED VS FEB 24 1960

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 35

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Laclede</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u> Length of stay in lb <u>25 yrs</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wallace Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Missouri</u> b. COUNTY <u>Laclede</u> c. CITY OR TOWN <u>Lebanon</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (if outside, give location) <u>Jefferson Hotel</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>David Newton Archer</u>			4. DATE OF DEATH Month Day Year <u>Feb. 15 1960</u>				
5. SEX <u>Male</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>12/14/1874</u>	9. AGE (last birthday) <u>85</u>	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) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (City and state or country) <u>Stoutland, Mo., U. S. A.</u>			
13a. FATHER'S NAME <u>William M. Archer</u>		13b. MOTHER'S MAIDEN NAME <u>Matilda Kissinger</u>		14. NAME OF HUSBAND OR WIFE <u>Jennie Pearl Archer</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>none</u>		17. INFORMANT Address <u>Mrs Velma Drake Lebanon Mo.</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>Generalized cardiac-vascular collapse</u> DUE TO (b) <u>cardiac revascularization</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>10 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>metastatic melanoma</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 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>1957</u> to <u>Feb. 15, 1960</u> and last saw him alive on <u>Feb. 15, 1960</u> Death occurred at <u>11:30 P. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>W. Carrington M.D.</u>			22b. ADDRESS <u>Lebanon, Mo.</u>		22c. DATE SIGNED <u>2-18-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/17/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Stoutland Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Stoutland, Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Worsey M. Howe Lebanon, Mo.</u>			25. DATE RECD. BY LOCAL (G.) <u>2-19-1960</u>	26. REGISTRAR'S SIGNATURE <u>Hella L. Hays</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 Dorsey M. Howe

Licensed Embalmer No. 422

P. O. Address Lebanon

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.