

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 21 1960

60-010279

STATE FILE NUMBER

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 24

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>		Length of stay in 1b <u>30 YRS.</u>	c. CITY OR TOWN <u>Excelsior Springs</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>709 North Main</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>709 North Main</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>LAKEN</u> Last <u>LAKEN</u>			4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>12-24-1885</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal</u>	11. BIRTHPLACE (City and state or country) <u>Penzburg, Germany</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>John LAKEN</u>		13b. MOTHER'S MAIDEN NAME <u>Antonia ?</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Pouche</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>491-01-8644</u>	17. INFORMANT <u>LAKEN</u> Address <u>Mrs. John LAKEN, 709 N. Main, Ex. Spgs, Mo</u>
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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 <u>seconds</u> <u>minutes</u> <u>years</u>
IMMEDIATE CAUSE (a)	<u>Acute Circulatory Failure</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<u>Coronary Thrombosis</u>	
DUE TO (b)	<u>Chronic Arteriosclerosis</u>	<u>years</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)		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> a.m. <u> </u> 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 2-22-60 to 2-25-60 and last saw her alive on 2-24-60.
Death occurred at 6:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Charles F. Lambert D.D.</u>	22b. ADDRESS <u>121 Excelsior St. Excelsior Springs, Mo.</u>	22c. DATE SIGNED <u>2-26-60.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2-29-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>
23d. LOCATION (City, town, or county) <u>Frontenac, Kansas</u>		

24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u> <u>Excelsior Springs, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>3-6-60</u>	26. REGISTRAR'S SIGNATURE <u>Baroline Hutchings</u>
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

VS MAR 21 1960

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

Lindell Jarman

Licensed Embalmer No. 4580
P. O. Address Excelsior Springs

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.