

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 3 1960

=60-014782

INDEXED

Registration District No. 120

Primary Registration District No. 4197

Registrar's No. 27

STATE FILE NUMBER

| | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|---|---|--|--|--|--|------------------------------|--|--------|--|-------|--|
| 1. PLACE OF DEATH a. COUNTY Gentry | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Gentry | | | | | | | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Stanberry | | Length of stay in 1b 2 yrs. | | c. CITY OR TOWN Stanberry | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 521 So. Stanberry St. | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 521 So. Stanberry St. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First MARTHA Middle LEE Last LOCKHART | | | | 4. DATE OF DEATH Month April Day 16 Year 1960 | | | | | | | | | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 6-18-87 | | 9. AGE (last birthday) 72 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HR Hours Min. | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | | 11. BIRTHPLACE (City and state or country) Lee County Virginia | | | 12. CITIZEN OF WHAT COUNTRY USA | | | | | | | | | | |
| 13a. FATHER'S NAME John Lawson | | | | 13b. MOTHER'S MAIDEN NAME Frances Bledsoe | | | | 14. NAME OF HUSBAND OR WIFE Andrew B. Lockhart, Sr. | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Mrs. Bonnie Esleman, Stanberry, Mo. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast DUE TO (b) unknown Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH @ 2 years | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None | | | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 Hour 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 11-30-54 to 4-16-60 and last saw her ^{her} alive on 4-16-60 Death occurred at 5:15 pm on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Arthur L. Carlin MD | | | | | | 22b. ADDRESS Stanberry, Missouri | | | | 22c. DATE SIGNED 4-22-60 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE April 18, 60 | | 23c. NAME OF CEMETERY OR CREMATORY High Ridge Cemetery | | | | 23d. LOCATION (City, town, or county) (State) Stanberry, Mo. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR JOHNSON FUNERAL HOMES, Stanberry, Mo. | | | | | | 25. DATE RECD. BY LOCAL REG. 4-24-60 | | 26. REGISTRAR'S SIGNATURE Mrs. D. W. Bare | | | | | | | | | | | |

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

Student _____
Signature of Student Embalmer

Signed

Ross Evan Johnson

Licensed Embalmer No. 494

P. O. Address Stanb

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.