

MORTUARY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-015953

FILED VS. APR 20 1960

170

Primary Registration District No. 3033

Registrar's No. 64

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Laclede		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Laclede	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lebanon		Length of stay in 1b 10 days	c. CITY OR TOWN Competition Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Louise G. Wallace		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Rural Rt. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ray Middle Edward Last Claxton		4. DATE OF DEATH Month April Day 8 Year 1960	
5. SEX male	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 8-19-98
9. AGE (last birthday) 61		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) farmer		10b. KIND OF BUSINESS OR INDUSTRY farming	11. BIRTHPLACE (City and state or country) Wright Co., Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Sam Claxton	
13b. MOTHER'S MAIDEN NAME Hillhouse		14. NAME OF HUSBAND OR WIFE Ruth Shamel Claxton	
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. 486-24-1822	17. INFORMANT Mrs. Ruth Claxton, Competition, 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) Cardiac Decompensation Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Myocardial insufficiency 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			INTERVAL BETWEEN ONSET AND DEATH 7 days ?
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 1953 to 4-8-60 and last saw her/him alive on 4-7-60 Death occurred at 7:45 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Do not use title) W. Carrington M.D.		22b. ADDRESS Lebanon, Mo.	
22c. DATE SIGNED 4-9-60			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 4-10-60	
23c. NAME OF CEMETERY OR CREMATORY Shamel Cemetery		23d. LOCATION (City, town, or county) (State) Laclede Co., Mo.	
24. FUNERAL DIRECTOR J. J. Shadel		25. DATE RECD. BY LOCAL REG. 4-9-1960	
ADDRESS Lebanon, Missouri		26. REGISTRAR'S SIGNATURE Hella L. Hays	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

APR 21 19

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 Gene C. Hunt

Licensed Embalmer No. 4734

P. O. Address Sydney, Mo

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.