

**FIL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-016407**

FILED VS APR 20 1960

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 28 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Pike</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Pike</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Louisiana</u>		c. CITY OR TOWN <u>Bowling Green</u>	
Length of stay in 1b <u>6 wks</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>Pike Co Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>Adams</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Lucille</u> Middle <u>Marie</u> Last <u>Ward</u>			4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>Female</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>4-8-1918</u>	9. AGE (last birthday) <u>41</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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pike Co, Missouri</u>		11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>

13a. FATHER'S NAME <u>Jack Van Strien</u>		13b. MOTHER'S MAIDEN NAME <u>Ermeye Griffith</u>		14. NAME OF HUSBAND OR WIFE <u>Frank Ward</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>UNKNOWN</u>		17. INFORMANT <u>Frank Ward, Bowling Green Mo</u> Address _____	

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral oedema.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinomatosis</u>			
DUE TO (c) <u>1° ca of endometrium</u>			
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 _____ 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>6-8-59</u> to <u>4-5-60</u> and last saw her alive on <u>4-5-60</u> . Death occurred at <u>4:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Deceased or title) <u>Roger F. Christensen MD</u>		22b. ADDRESS <u>Louisiana Mo.</u>		22c. DATE SIGNED <u>4-5-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-7-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Buffalo Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Louisiana Mo</u>

24. FUNERAL DIRECTOR <u>Bankhead Funeral Chapel</u>	ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>April 12, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 2

STATEMENT BY LICENSED EMBALMER MAY 11 1980

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 Harold Kirk

Licensed Embalmer No. 4597

P. O. Address Bowling

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.