

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

**-60-027756**

**FILED VS JUL 25 1960**

STATE FILE NUMBER

Registration District No. 251 Primary Registration District No. \_\_\_\_\_ Registrar's No. 171

1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Nodaway</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jackson</u>		Length of stay in 1b <u>7 weeks</u>		c. CITY OR TOWN <u>Pickering</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>R.F.D. #2 Pickering, Mo.</u>				d. STREET ADDRESS (If outside, give location) <u>Pickering</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>F.</u> Last <u>Lucas</u>				4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>Female</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>Feb. 12, 1868</u>	9. AGE (last birthday) <u>92</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>none</u>		11. BIRTHPLACE (City and state or country) <u>Hawkins Co. Tennessee</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Isom Dykes</u>			13b. MOTHER'S MAIDEN NAME <u>Sally Mullen</u>		14. NAME OF HUSBAND OR WIFE <u>Francis M. Lucas</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 <u>Charles Lucas</u> Address <u>Gravity, Ia.</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>Lobar Pneumonia</u> DUE TO (b) <u>Flu</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
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 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>June 1 - 12</u> to <u>June 12</u> and last saw her <u>alive</u> on <u>June 12-60</u> Death occurred at <u>Pickering Mo</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>R. G. Garten D.O.</u>				22b. ADDRESS <u>Maryville Mo</u>		22c. DATE SIGNED <u>7-18-60</u>	
23a. BURIAL, REMOVAL, OR CREMATION (Specify) <u>Burial</u>	23b. DATE <u>6.14.1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Braddyville</u>		23d. LOCATION (City, town, or county) (State) <u>Braddyville, Iowa</u>			
24. FUNERAL DIRECTOR <u>Davis Funeral Home</u> ADDRESS <u>T.arkio, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>7-18 60</u>		26. REGISTRAR'S SIGNATURE <u>Bessie Bolt</u>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

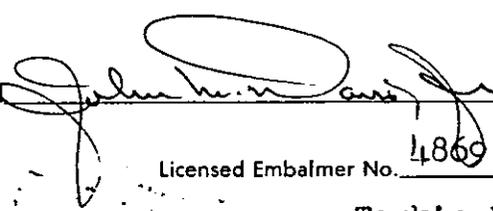
MEDICAL CERTIFICATION

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  \_\_\_\_\_

Licensed Embalmer No. 4869

P. O. Address Tarkio, Mo.

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