

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028005

FILED VS AUG 15 1960

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Primary Registration District No. 4459

Registrar's No. 44

STATE FILE NUMBER

DEED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>ST CLAIR</b>	b. CITY (If outside corporate limits, give TOWNSHIP only) <b>OSCEOLA</b>	a. STATE <b>MO</b>	b. COUNTY <b>ST CLAIR</b>
Length of stay in lb <b>204n</b>		c. CITY OR TOWN <b>OSCEOLA</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mod Hospital</b>		d. STREET ADDRESS (if outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>NETTIE</b>	Middle <b>-</b>	Last <b>LUCAS</b>	4. DATE OF DEATH	Month <b>JULY</b>	Day <b>30</b>	Year <b>1960</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-7-61</b>	9. AGE (last birthday) <b>98</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPING</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>UNKNOWN</b>	13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>Bert Biologic Osceola MO</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>3w</b>
IMMEDIATE CAUSE (a)	<b>Frangrens. left foot leg</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>angio thrombotic</b>	
	DUE TO (c) <b>senility</b>	
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.)
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20c. TIME OF INJURY	Hour -a.m. -p.m.	Month, Day, Year
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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
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21. I attended the deceased from **Oct 1959** to **July 30-60** and last saw her alive on **July 30-60**  
Death occurred at **7:00 P** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Ruth Seewers MD</b>	(Degree or title)	22b. ADDRESS <b>Osceola MO</b>	22c. DATE SIGNED <b>8-3-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-2-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Union</b>	23d. LOCATION (City, town, or county) (State) <b>Vista MO</b>
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24. FUNERAL DIRECTOR <b>Goodrich Home, Osceola</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>8-3-60</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Seewers</b>
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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 Paul Tristone

Licensed Embalmer No. 3990

P. O. Address Oswala 7

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.