

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031180

FILED VS SEP 7 1960

STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 5644 Registrar's No. 81

UNRECORDED

1. PLACE OF DEATH a. COUNTY Lafayette				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Missouri Lafayette									
b. CITY (If outside corporate limits, give TOWNSHIP only) in car Lexington Twnshp		Length of stay in 1b Minutes		c. CITY OR TOWN Mayview		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF HOSPITAL OR INSTITUTION INCORPORATE South of Lexington,			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) South of Mayview		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last IZOLA BELLE ILES				4. DATE OF DEATH Month Day Year August 21, 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. BIRTHDATE December 8, 1901		9. AGE (last birthday) 58		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (City and state or country) Lexington, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A					
13a. FATHER'S NAME Charles L. Fizer				13b. MOTHER'S MAIDEN NAME Mintie Lee Stover				14. NAME OF HUSBAND OR WIFE Ernest Iles					
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 Mr. Ernest Iles Mayview, 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) Coronary Thrombosis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH Sudden			
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 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 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 3:30 A. to 8/21/60 and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) Joe W Warden						22b. ADDRESS Lexington Mo			22c. DATE SIGNED 8/24/60				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/23/60		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.				23d. LOCATION (City, town, or county) (State) Lexington, Mo.					
24. FUNERAL DIRECTOR ADDRESS Vaughn-Walker Lexington, Mo.						25. DATE RECD. BY LOCAL REG. 8-25-60		26. REGISTRAR'S SIGNATURE Walter E. Eastman					

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

Student _____
Signature of Student Embalmer

Signed Harold L. Walker

Licensed Embalmer No. 4588

P. O. Address Lexington

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.