

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033902

FILED VS SEP 19 1960

042

Primary Registration District No. 1000

Registrar's No. 972

STATE FILE NUMBER

INDEXED

| | | | | | | | |
|---|---|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Buchanan | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Missouri b. COUNTY Buchanan | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | Length of stay in 1b 40 yrs | | c. CITY OR TOWN St. Joseph | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1008 Prospect Ave. | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1008 Prospect Ave | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First JAMES Middle HARVE Last LAWLESS | | | | 4. DATE OF DEATH Month Sept. Day 12 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 9/12/1888 | 9. AGE (last birthday) 72 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Yardman | | | 10b. KIND OF BUSINESS OR INDUSTRY Lumber Company | | 11. BIRTHPLACE (City and state or country) Platte County Missouri | | 12. CITIZEN OF WHAT COUNTRY U S A |
| 13a. FATHER'S NAME James Lawless | | | 13b. MOTHER'S MAIDEN NAME Jenny Shackelford | | | 14. NAME OF HUSBAND OR WIFE Mrs. Ruby L. Lawless | |
| 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. 491-09-2950 | 17. INFORMANT Mrs. Ruby L. Lawless | | Address 1008 Prospect St. Joseph, 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) CEREBRAL HEMORRHAGE | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 12 HOURS |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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 | |
| 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____ | | | | | | | |
| 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 SEPT. 11, 1960 to SEPT 12, 1960 and last saw ^{xxx} him alive on SEPT. 4, 1960 Death occurred at 3:45A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE L.H. Pifer, M.D. (Degree or title) | | | | 22b. ADDRESS 1302 FANON ST. JOSEPH | | 22c. DATE SIGNED 9-12-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 9/14/60 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery | | 23d. LOCATION (City, town, or county) St. Joseph Missouri | | (State) |
| 24. FUNERAL DIRECTOR Stamey Funeral Home N.A.S. | | | ADDRESS St. Joseph, Mo. | | 25. DATE RECD. BY LOCAL REG. Sept. 15, 1960 | 26. REGISTRAR'S SIGNATURE Mrs. Clark Gardell | |

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 Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St. Joseph

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.