

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034082  
STATE FILE NUMBER

FILED VS OCT 3 1960 53 Primary Registration District No. 3010 Registrar's No. 387

1. PLACE OF DEATH a. COUNTY <i>Cape Girardeau</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Cape Girardeau</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Cape Girardeau</i>		Length of stay in lb <i>2 weeks</i>	c. CITY OR TOWN <i>Jackson</i>		- Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Southern Hospital</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>Cape Road</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>ADELAIDE - LAPIERRE</i>			4. DATE OF DEATH Month Day Year <i>Sept 20 - 1960</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 5, 1871</i>	9. AGE (last birthday) <i>83</i>	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) <i>Librarian</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Librarian</i>		11. BIRTHPLACE (City and state or country) <i>Jackson Mo.</i>	
12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>		13a. FATHER'S NAME <i>Zepherin M. Lapierre</i>		13b. MOTHER'S MAIDEN NAME <i>Mary Welling</i>	
14. NAME OF HUSBAND OR WIFE <i>none</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>498-34-4043</i>	
17. INFORMANT <i>Chas F. Lapierre</i>		Address <i>Jackson Mo</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Generalized arteriosclerosis &amp; renal failure</i>		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		INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 yrs</i>	
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 s.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 <i>May 1950</i> to <i>9-20-60</i> and last saw her <sup>her</sup> <sub>him</sub> alive on <i>9-19-60</i> Death occurred at <i>1:30 A.</i> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>E. F. McDonald, M.D.</i>			22b. ADDRESS <i>Jackson, Mo.</i>		22c. DATE SIGNED <i>9-26-60</i>
23a. BURIAL, CREMATION, REINTERMENT (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<i>Burial</i>	<i>Sept 21-1960</i>	<i>City Cem.</i>		<i>Jackson Mo</i>	
24. FUNERAL HOME OR ADDRESS <i>Miller Jackson Mo</i>		25. DATE RECD. BY LOCAL REG <i>9-30-60</i>		26. REGISTRAR'S SIGNATURE <i>Gene Kasten</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 24 1961

**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 *[Handwritten Signature]*

Licensed Embalmer No. 4327

P. O. Address *[Handwritten Address]*

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.