

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-038042

LED VS OCT 24 1960

STATE FILE NUMBER

ENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 997A

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Greene</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> | | Length of stay in 1b <u>1 day</u> | c. CITY OR TOWN <u>Ash Grove</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Landley Hosp</u> | | Inside Units Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

| | | | | |
|--|--|--|---|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>CARRIE BELL LAKEY</u> | | | 4. DATE OF DEATH Month Day Year <u>Sept-29-60</u> | |
|--|--|--|---|--|

| | | | | | | |
|----------------------|-------------------------------|---|-----------------------------------|----------------------------------|---|----------------|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-27-1913</u> | 9. AGE (last birthday) <u>47</u> | 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) <u>Housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Mississippi</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
|--|-----------------------------------|---|---|

| | | |
|---|---|--|
| 13a. FATHER'S NAME <u>Stellie James Isaac Bellard</u> | 13b. MOTHER'S MAIDEN NAME <u>Rosa Lee Burks</u> | 14. NAME OF HUSBAND OR WIFE <u>Marion Alfred Lakey</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. | 17. INFORMANT <u>Marion Alfred Lakey - Ash Grove, Mo.</u> Address |
|--|-------------------------|--|

| | | |
|---|--|----------------------------------|
| 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>Carcinoma of Cervix c</u> <u>Extensive Metastasis</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| 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 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 | <u>9/28/60</u> |
|---|----------------|

| | | |
|--|--|---|
| 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>9/28/60</u> to <u>9/29/60</u> and last saw her alive on <u>9/29/60</u> | |
| Death occurred at <u>9:15 p.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | |

| | | |
|--|---------------------------------------|------------------------------------|
| 22a. SIGNATURE (Degree or title) <u>Lyman R. Brown M.D.</u> | 22b. ADDRESS <u>31 1/2 College</u> | 22c. DATE SIGNED <u>9/30/60</u> |
|--|---------------------------------------|------------------------------------|

| | | | |
|--|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>10-1-60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt Pleasant Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Ash Grove - Mo.</u> |
|--|-----------------------------|---|---|

| | | | |
|--|---------|---|---|
| 24. FUNERAL DIRECTOR <u>Brun - Daniel - Ash Grove - Mo.</u> | ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>10-19-60</u> | 26. REGISTRAR'S SIGNATURE <u>Effie L. Melton</u> |
|--|---------|---|---|

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 25 1960

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 _____
Wayne L. Sauer

Licensed Embalmer No. 470

P. O. Address Oshtemo

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.