

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038979

FILED VS OCT 27 1960  
 Registration District No. Vo o

Primary Registration District No. 3041

Registrar's No. 162

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Macon</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Macon</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Macon</u>		Length of stay in lb <u>1/3.</u>	c. CITY OR TOWN <u>Macon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>901 S. Rollins</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>901 S. Rollins</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Bert</u> Middle <u>Virgil</u> Last <u>Lucas</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>7</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3/15/1883</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trucker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (City and state or country) <u>Macon County Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>John Lucas</u>		13b. MOTHER'S MAIDEN NAME <u>Ava Walters</u>		14. NAME OF HUSBAND OR WIFE <u>No.</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. <u>No.</u>		17. INFORMANT Address <u>Clarence Lucas Jacksonville Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>bronchial pneumonia</u>					<u>3 day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <u>uro-sensis</u>					<u>9 day</u>
DUE TO (c) <u>paralysis agitans</u>					<u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>prolonged recumbency</u>					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 _____ 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 <u>2-16-60</u> to <u>8-6-60</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>8-6-60</u> Death occurred at <u>9:15</u> <u>P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>L. D. Durdan</u>			22b. ADDRESS <u>701 Macon, Missouri</u>		22c. DATE SIGNED <u>10-10-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct. 9, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Salem Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Excelsior, Mo.</u>
24. FUNERAL DIRECTOR <u>Lester Hutton</u>		ADDRESS <u>Macon, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10/15/60</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Neely</u>

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 L. Nutton

Licensed Embalmer No. 4577

P. O. Address Macow, I

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co  
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.