

**JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS NOV 17 1960

378

Primary Registration District No. ~~4552~~

6285

Registrar's No.

57

=60-044972

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Wright</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wright</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mtn. Grove</u>		Length of stay in 1b <u>10 yrs.</u>		c. CITY OR TOWN <u>Mountain Grove</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4 mi South Mtn. Grove</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4 Mi. South</u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>L.</u> Last <u>Hicks</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>4th</u> Year <u>1960</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>12-31-1890</u>	9. AGE (last birthday) <u>69</u>	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) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and state or country) <u>Vanzant (Douglas) Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>John H. Smith</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Wallace</u>			14. NAME OF HUSBAND OR WIFE <u>Robert Hicks</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>None</u>		17. INFORMANT Address <u>Robert Hicks Mtn. Grove, Missouri</u>				
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>CORONARY OCCLUSION</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u>							<u>10 years</u>		
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 _____ 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>11/1/58</u> to <u>11/4/60</u> and last saw her <u>alive</u> on <u>11/1/60</u> Death occurred at <u>8:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>J. L. Spears M.D.</u> (Degree or title)				22b. ADDRESS <u>Cabool, Mo</u>				22c. DATE SIGNED <u>11/7/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-7-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Vanzant Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Vanzant Douglas Missouri</u>				
24. FUNERAL DIRECTOR ADDRESS <u>W. ell C. Craig Mtn. Grove, Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>11-8-1960</u>		26. REGISTRAR'S SIGNATURE <u>Bernard Silverman</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 Newell C. Caran

Licensed Embalmer No. 4764

P. O. Address Mt. Airy

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.