

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046741

LED VS. DEC 23 1960

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 164

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Linn</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Linn</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marceline</u>		Length of stay in 1b <u>6ds</u>		c. CITY OR TOWN <u>Marceline</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>St Francis Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>312 E. Grace</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>F.</u> Last <u>Lair</u>				4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>1960</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>4-19-1885</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state or country) <u>Chariton, Co</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		
13a. FATHER'S NAME <u>M.J.</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Kovacs</u>		14. NAME OF HUSBAND OR WIFE <u>Grace</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>Omerlain Marceline 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>Acute myocardial infarction</u> DUE TO (b) <u>Coronary Arteriosclerosis + Insufficiency</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>approx 4 wks</u> <u>Indefinite</u>		
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"/> N. <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 <u></u> a.m. <u></u> p.m. <u></u>	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>25 September 60</u> to <u>7 Dec 60</u> and last saw ^{her} _{him} alive on <u>7 Dec 60</u> Death occurred at <u>12:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Deceased or title) <u>Lemon A Turner, M.D.</u>				22b. ADDRESS <u>Marceline, MO</u>		22c. DATE SIGNED <u>8 Dec 60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	23b. DATE <u>12-10-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MTD) IVOT</u>		23d. LOCATION (City, town, or county) (State) <u>Marceline MO.</u>				
24. FUNERAL DIRECTOR <u>James M'Laughlin Marceline, MO</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>12-9-60</u>		26. REGISTRAR'S SIGNATURE <u>Brookia Owens</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 28 1960

JAN 10 1961

GLENWOOD

~~HOLPER~~
HOLPER
17.12

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 Paul I. Wain

Licensed Embalmer No. 4172

P. O. Address Brown

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.