

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-000746

FILED VS JAN 11 1961 93

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 4154 Registrar's No. 61-1

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ  
 TYPEWRITER RIBBON

|   |  |   |   |   |   |   |  |  |                                |   |  |  |  |
|---|--|---|---|---|---|---|--|--|--------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Dade</u>  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>                           |   |   |  |  |                                |   |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>So. Greenfield Mo</u>  |  | Length of stay in 1b yrs <u>      </u>  |   | c. CITY OR TOWN <u>So. Greenfield Mo.</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>Home</u>   |  |   | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location) <u>So Greenfield Mo</u> |   | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |                                |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Laura</u> Middle <u>Arena</u> Last <u>Fuqua</u>   |  |   |   | 4. DATE OF DEATH<br>Month <u>Jan</u> Day <u>2</u> Year <u>1961</u>  |   |   |  |  |                                |   |  |  |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>White</u>   |   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH <u>Jan 28 1880</u>   |  | 9. AGE (last birthday) <u>80</u>   |                                | IF UNDER 1 YEAR<br>Months <u>11</u> Days <u>4</u> |  | IF UNDER 24 HR<br>Hours <u>      </u> Min. <u>      </u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired House Wife</u>   |  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>   |   | 11. BIRTHPLACE (City and state or country) <u>Dade Co Mo</u>                      |  | 12. CITIZEN OF WHAT COUNTRY <u>USA</u>   |                                |   |  |  |  |
| 13a. FATHER'S NAME <u>Joseph H Renfro</u>   |  |   |   | 13b. MOTHER'S MAIDEN NAME <u>Mary J Merrick</u>   |   |   |  | 14. NAME OF HUSBAND OR WIFE <u>James Harve Fuqua</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>      </u>   |   | 17. INFORMANT Address <u>Marie Fuqua So. Greenfield Mo.</u>                       |  |  |                                |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer of liver</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____<br>DUE TO (c) _____ |  |   |   |   |   |   |  |  |                                | INTERVAL BETWEEN ONSET AND DEATH                  |  |  |  |
| 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.<br><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 _____ 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>6-1-60</u> to <u>1-2-61</u> and last saw her/him alive on <u>1-1-61</u><br>Death occurred at <u>10:00P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.   |  |   |   |   |   |   |  |  |                                |   |  |  |  |
| 22a. SIGNATURE (Degree or title) <u>Thos. Cowan M.D.</u>  |  |   |   |   |   | 22b. ADDRESS <u>Greenfield</u>  |  |  | 22c. DATE SIGNED <u>1-4-61</u> |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE <u>Jan 5 1961</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenfield</u>  |   | 23d. LOCATION (City, town, or county) (State) <u>Greenfield Mo.</u>               |  |  |                                |   |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS <u>Allison Funeral Home Greenfield M.</u>  |  |   |   | 25. DATE RECD. BY LOCAL REG. <u>1-9-1961</u>  |   | 26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>                                     |  |  |                                |   |  |  |  |

**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 W. R. Allison

Licensed Embalmer No. 4404  
P. O. Address Weymouth

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.