

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-005217

STATE FILE NUMBER

AMENDED FILED VS MAR 6 1961 Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 33

1. PLACE OF DEATH a. COUNTY <i>Waverly</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Waverly</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>West Plains</i>		Length of stay in 1b <i>6 years</i>	c. CITY OR TOWN <i>West Plains</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Rt 1</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>Rt 1</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>Jilda M. Lane</i>			4. DATE OF DEATH Month Day Year <i>2-22-1961</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>3-1-1880</i>	9. AGE (last birthday) <i>80</i>	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) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (City and state or country) <i>Tennessee</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	

13a. FATHER'S NAME <i>Geo. Lepton</i>		13b. MOTHER'S MAIDEN NAME <i>Nancy ?</i>		14. NAME OF HUSBAND OR WIFE <i>-</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Gray Lane, West Plains Mo</i> Address	

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 <i>6 weeks</i>
IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>			
DUE TO (b) <i>Arteriosclerotic heart disease</i>			
DUE TO (c) _____			<i>4 years</i>

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					

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 *1957* to *2/22/61* and last saw her *alive* on *2/22/61*
Death occurred at *2:45 A* m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>M. T. Fowler MD</i>	22b. ADDRESS <i>West Plains Mo</i>	22c. DATE SIGNED <i>2/28/61</i>
--	---------------------------------------	------------------------------------

23a. BURIAL CREMATION, REMOVAL (Specify) <i>B</i>	23b. DATE <i>2/26-61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Newsperry</i>	23d. LOCATION (City, town, or county) (State) <i>West Plains Mo</i>
--	-----------------------------	--	--

24. FUNERAL DIRECTOR <i>Robert W. West Plains Mo</i> ADDRESS	25. DATE RECD. BY LOCAL REG. <i>3-3-61</i>	26. REGISTRAR'S SIGNATURE <i>Beatrice Cook</i>
--	---	---

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *D. S. Roberts*

Licensed Embalmer No. 3437

P. O. Address *West Plain*

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.