

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-006056

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 267 Primary Registration District No. 4400 Registrar's No. 116 27

FILED VS MAR 3 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Pemiscot</u>	b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bragg City</u>	a. STATE <u>Mo.</u>	b. COUNTY <u>Pemiscot</u>
Length of stay in 1b		c. CITY OR TOWN <u>Bragg City</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>Rural Route 1</u>		d. STREET ADDRESS <u>Rural Route 1</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Ida</u>	Middle <u>Caroline</u>	Last <u>Vickery</u>	4. DATE OF DEATH	Month <u>Feb.</u>	Day <u>15</u>	Year <u>1961</u>
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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>8-18-1893</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>27</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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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 <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Tenn.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>William Pratt</u>	13b. MOTHER'S MAIDEN NAME <u>Lizzie Jones</u>	14. NAME OF HUSBAND OR WIFE <u>R.W. Vickery</u>
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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 <u>R.W. Vickery</u>	Address <u>Bragg City, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		<u>p</u>
IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>	DUE TO (b)	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Foud down Rt femoral Hemiar year</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
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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.)
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year <u></u> <u></u> <u></u>
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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 <u>Kennett</u>	COUNTY <u>Missouri</u>	STATE <u>Missouri</u>
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21. I attended the deceased from 12-23-60 to 2-15-61 and last saw him alive on 12-29-60
Death occurred at approximately 7:30a on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Paul Milton Lyon M.D.</u>	22b. ADDRESS <u>Kennett, Missouri</u>	22c. DATE SIGNED <u>2-22-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-17-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Ridge</u>	23d. LOCATION (City, town, or county) (State) <u>Kennett Missouri</u>
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24. FUNERAL DIRECTOR <u>McDaniel Funeral Ser. Kennett, Mo.</u>	ADDRESS <u></u>	25. DATE RECD. BY LOCAL REG. <u>2-27-61</u>	26. REGISTRAR'S SIGNATURE <u>Charlotte E. Sloan</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Thomas J. Roberts

Licensed Embalmer No. 4886

P. O. Address Kennett, Va.

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.