

FILED MAR 21 1961

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

-61-008142

STATE FILE NUMBER

Registration District No. 83 Primary Registration District No. 5314 Registrar's No. 5

V. S. 300
Rev. 1-57

270

The funeral director is responsible for the proper completion of the entire certificate. This includes securing the medical certification in the specific manner required by 193.140 MoRS 1949.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>COOPER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Cooper</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWNSHIP <u>PRairie HOME</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>WOOLDRIDGE</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>90</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>WOOLDRIDGE Mo</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>SILAS</u> Last <u>LAMM</u>		4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 17 1896</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>Cooper Co.</u>
13a. FATHER'S NAME <u>WILLIAM LAMM</u>		13b. MOTHER'S MAIDEN NAME <u>FANNIE GILES</u>	14. NAME OF DECEASED'S WIFE <u>ETHEL LEE</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>Vergie M. Adair</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>Uremia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>chronic nephritis</u> DUE TO (c) <u>Diabetes.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
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 <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>260X</u>	
21. I attended the deceased from <u>1950</u> to <u>March 13</u> and last saw her/him alive on <u>March 13, 1961</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Alfred R. Roversway MD</u>		22b. ADDRESS <u>Boonville, Mo</u>	
		22c. DATE SIGNED <u>Mar ch 16 1961</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3/17/1961</u>	23c. NAME OF CEMETERY OR CREMATOR <u>CLAYTON</u>	23d. LOCATION (City, town, or county) (State) <u>NEAR WOOLDRIDGE MO.</u>
24. FUNERAL DIRECTOR <u>GALBERT HORNBECK</u> ADDRESS <u>PRairie HOME MO</u>		25. DATE RECD. BY LOCAL REG. <u>3/17/61</u>	
		26. REGISTRAR'S SIGNATURE <u>Virginia T. Higgins</u>	

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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 *G. Albert Hornbeck*

Licensed Embalmer No. *2714*

P. O. *ARLIE HOME*

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.