

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-025836

STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 60

FILED AUG 14 1961

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) MISSOURI b. COUNTY <u>Lafayette</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>			Length of stay in 1b <u>Two Wks.</u>		c. CITY OR TOWN <u>Lexington</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>Lexington Memorial Hospital</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>W.R. #2</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ROY</u> Middle <u>W.</u> Last <u>STONE</u>				4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1961</u>				
5. SEX <u>Male</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. BIRTH <u>July, 10,</u>	9. AGE (last birthday) <u>60</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 24 HR Hours	IF UNDER 24 HR Min.
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>Agriculture</u>		11. BIRTHPLACE (City and state or country) <u>Wheatland, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>George Washington Terry</u>			13b. MOTHER'S MAIDEN NAME <u>Angeline Taylor</u>			14. NAME OF HUSBAND OR WIFE <u>Bertha Fairchild</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>					17. INFORMANT Address <u>Mrs. Bertha Stone Lexington, Mo</u>			
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>Rupture gastric valve of heart, 24 hrs</u> DUE TO (b) <u>Subacute bacterial endocarditis 6 weeks</u> DUE TO (c) <u>Septicemia, origin undetermined 8 weeks</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"/> No <input type="checkbox"/> Unknown								
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 <u>July 3 1961</u> to <u>July 24 1961</u> and last saw him alive on <u>July 24 1961</u> Death occurred at <u>7:48 Pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Ralph Walker MD</u>				22b. ADDRESS <u>Lexington, Mo.</u>		22c. DATE SIGNED <u>7-25-61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7/27/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lexington Memory Gardens</u>		23d. LOCATION (City, town, or county) <u>Lexington, Mo.</u>		
24. FUNERAL DIRECTOR <u>Vaughn-Walker Lexington, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>7-27-61</u>		26. REGISTRAR'S SIGNATURE <u>Marion S. ...</u>		

OCT 18 1961

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 Paul H. Wilson Student Embalmer No. 634
working under my personal supervision.

Student Paul H. Wilson
Signature of Student Embalmer

Signed Harold L. Walker

Licensed Embalmer No. 4588

P. O. Address Lexington

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.