

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-035983

042

1000

1088

STATE FILE NUMBER

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED NOV 6 1961

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Nodaway	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 8m 9d	c. CITY OR TOWN BARNARD Inside Limits Under 1000
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph State Hosp		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) un known Reside on Farm Under 1000

3. NAME OF DECEASED (Type or print) First James Middle William Last Lucas	4. DATE OF DEATH Month 10 Day 24 Year 1961
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5. SEX Male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/25/1870	9. AGE (last birthday) 91	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	10b. KIND OF BUSINESS OR INDUSTRY farming	11. BIRTHPLACE (City and state or country) No daway, Co	12. CITIZEN OF WHAT COUNTRY
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13a. FATHER'S NAME John Lucas	13b. MOTHER'S MAIDEN NAME Flora Stingley	14. NAME OF HUSBAND OR WIFE Mary Jane Lucas
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Record St. Joseph State Hosp.
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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
IMMEDIATE CAUSE (a) Congestive heart failure		7 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic heart disease	?
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition Cataract, Arteriosclerosis, Brain Syndrome & Senility, Uremia, Mild Diabetes, Lipoma left shoulder	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 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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	COUNTY	STATE
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21. I attended the deceased from **June, 1961** to **July** and last saw him **at record body 10/24/61**
Death occurred at **2** **PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Mary Barnes, M.D. (Degree or title)	22b. ADDRESS St. Joseph Mo	22c. DATE SIGNED 10/24/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-28-1961	23c. NAME OF CEMETERY OR CREMATORY Barnard Cem -	23d. LOCATION (City, town, or county) (State) Barnard - Mo
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24. FUNERAL DIRECTOR Atchison - Maryville, Mo, ADDRESS	25. DATE RECD. BY LOCAL REG. Oct. 27, 1961	26. REGISTRAR'S SIGNATURE Mr. Clark Goodell
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
INSTEAD OF
DOCUMENT
BY AFFIDAVIT OF
ITEM NO.
SHOULD READ
M.B. Ames, M.D. MEDICAL CERTIFICATION

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. M. Atkinson

Licensed Embalmer No. 2279

P. O. Address Kingville

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.