

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039794

STATE FILE NUMBER

AMENDED

Registration District No. 325 Primary Registration District No. 6094 Registrar's No. 32

FILED NOV 3 1961

1. PLACE OF DEATH a. COUNTY SCHUYLER		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MISSOURI b. COUNTY SCHUYLER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CHARITON		Length of stay in 1b 4 YEARS	c. CITY OR TOWN GLENWOOD Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION HOME		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) NONE Residence on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First CAROLINE Middle HICKS Last MCDADE	4. DATE OF DEATH Month OCT. Day 25 Year 1961
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/30/1861	9. AGE (last birthday) 100	IF UNDER 1 YEAR Months 8 Days 25 Hours Min. 	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	11. BIRTHPLACE (City and state or country) VERMILLION COUNTY, ILL.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME David Hicks	13b. MOTHER'S MAIDEN NAME Elizabeth Looman	14. NAME OF HUSBAND OR WIFE John Franklin Mc Dade
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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 Agusta Ford, Glenwood, Mo.	Address
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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)	Medullary failure	11 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral thrombosis	
	DUE TO (c) Senility and arteriosclerosis	
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 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 checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION LANCASTER, MO.	COUNTY LANCASTER	STATE MO.
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21. I attended the deceased from **Oct. 15, 1961** to **Oct. 25, 1961** and last saw her **alive** on **Oct. 25, 1961**
Death occurred at **2:45** P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE H. R. Stoker D.O.	(Degree or title)	22b. ADDRESS Lancaster, Mo.	22c. DATE SIGNED 10-26-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10/28/1961	23c. NAME OF CEMETERY OR CREMATORY PLEASANT GROVE CEMETERY, CHARITON COUNTY, MO.	23d. LOCATION (City, town, or county) (State) LANCASTER, MO.
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24. FUNERAL DIRECTOR NORMAN FUNERAL HOME, LANCASTER, MO.	ADDRESS	25. DATE RECD. BY LOCAL REG. 10-30-61	26. REGISTRAR'S SIGNATURE Lorence Shepherd
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

Permit not obtained

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 Joseph E. Foster

Licensed Embalmer No. 4742

P. O. Address Ferrell, Pa.

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.