

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=61-040007**

STATE FILE NUMBER

AMENDED

Registered District No. 1 Primary Registration District No. 3000 Registrar's No. 342

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Adair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>		Length of stay in 1b <b>years</b>	c. CITY OR TOWN <b>Kirksville</b>
c. FULL NAME OF (If NOT in hospital, give location) <del>XXXXXXXXXX</del> <b>702 N. Franklin</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>702 N. Franklin</b>
3. NAME OF DECEASED (Type or print) First <b>VICIE</b> Middle <b>L.</b> Last <b>WORTHINGTON</b>		4. DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10/12/93</b>
9. AGE (last birthday) <b>68</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Schuyler Co. Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U S</b>		13a. FATHER'S NAME <b>Whitaker Lourance</b>	
13b. MOTHER'S MAIDEN NAME <b>Lorinda Gier</b>		14. NAME OF HUSBAND <del>DECEASED</del> <b>Morton W. (dec'd)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT Address <b>Earl Worthington, Independence, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b>			INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 checked="" 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.)	
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 checked="" 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 <b>August 10, 1961</b> to <b>Nov 22, 1961</b> and last saw her alive on <b>Nov 22, 1961</b> Death occurred at <b>11:35 a</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>R H Turner D.O.</b>		22b. ADDRESS <b>Kirksville, Mo.</b>	22c. DATE SIGNED <b>11/24/61</b>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/25/61</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Maple Hill</b>	23d. LOCATION (City, town, or county) (State) <b>Kirksville, Adair, Mo.</b>
24. FUNERAL DIRECTOR <b>Foster Memorial Home, Kirksville, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-24-1961</b>	26. REGISTRAR'S SIGNATURE <b>Dora W. Ratliff</b>

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATE OF DEATH  
**DR. R. H. TURNER**

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

DEC 5 1961

R. H. TURNER, D.O.

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 *Nova E. Foster*  
Nova E. Foster

Licensed Embalmer No. 4742

P. O. Address Kirksville, Mo.

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.