

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040322

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 293 STATE FILE NUMBER

AMENDED

FILED DEC 11 1961

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| 1. PLACE OF DEATH a. COUNTY <u>Callaway</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Boone</u> | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u> | | Length of stay in lb <u>6 wks.</u> | c. CITY OR TOWN <u>Columbia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Missouri State H</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>1402 West Worley</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Middle Last <u>LaRoe Jack LaRoe</u> | | | 4. DATE OF DEATH Month Day Year <u>December 3 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. DATE OF BIRTH <u>1/22/1915</u> | 9. AGE (last birthday) <u>76</u> | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u> | 11. BIRTHPLACE (City and state or country) <u>Missouri</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u> | |
| 13a. FATHER'S NAME <u>Taylor LaRoe</u> | | 13b. MOTHER'S MAIDEN NAME <u>Katherine Morean</u> | | 14. NAME OF HUSBAND OR WIFE <u>Lida LaRoe</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u> | | 16. SOCIAL SECURITY NO. <u>unk</u> | 17. INFORMANT Address <u>State Hospital #1 Fulton, Mo</u> | | |

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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: IMMEDIATE CAUSE (a) <u>Brain-subarachnoid hemorrhages, recent etiology? (pending completion of autopsy)</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | |
| | DUE TO (c) | |

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| 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 | |
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| 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 _____ to _____ and last saw ^{her}him alive on 1 PM
Death occurred at 1 PM - 12/3/61 m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>Fred P. Henderson</u> | | 22b. ADDRESS <u>Fulton, Mo</u> | 22c. DATE SIGNED <u>30 Dec 61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>12-5-1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Boone Femme</u> | 23d. LOCATION (City, town, or county) (State) <u>Columbia Mo</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Lyman Spunkle Columbia, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>Dec 4 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Maretta Lawrence</u> |

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

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

Lyman H. Sprinkle

Licensed Embalmer No. *4013*

P. O. Address *Columbia, 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.