

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-61-040437**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 21 Primary Registration District No. 3012 Registrar's No. 114

**FILED NOV 21 1961**

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>			Length of stay in lb		c. CITY OR TOWN <u>Excelsior Springs</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Excelsior Springs Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>109 Temple</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Charlotte</u> Middle <u>LaBarr</u> Last <u>LaBarr</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-6-1882</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>		IF UNDER 24 HR Hours <u>    </u> Min. <u>    </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>DeWitt, Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Isaac Jones</u>			13b. MOTHER'S MAIDEN NAME <u>Emma Jane Dawson</u>			14. NAME OF HUSBAND OR WIFE <u>Charles LaBarr</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>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Kenneth LaBarr, Kearney, Missouri</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>Pulmonary Embolism</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
DUE TO (b) <u>Basal Ganglia Lower Extremity Thrombophlebitis</u>						<u>1 year</u>	
DUE TO (c) <u>    </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Acute Cholelithiasis &amp; Cholecystitis</u>						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 <u>    </u> a.m. <u>    </u> p.m. <u>    </u> Month, Day, Year <u>    </u>		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>Aug 1961</u> to <u>Nov 9, 1961</u> and last saw her/him alive on <u>11-9-61</u> . Death occurred at <u>12:25</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>James R. Allan, M.D.</u> (Degree or title)				22b. ADDRESS <u>Excelsior Springs, Mo</u>		22c. DATE SIGNED <u>11-9-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-11-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		23d. LOCATION (City, town, or county) (State) <u>Kearney, Mo.</u>		
24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u> ADDRESS <u>Excelsior Springs, Missouri</u>			25. DATE RECD. BY LOCAL REG. <u>11-16-61</u>		26. REGISTRAR'S SIGNATURE <u>Baroline Hutchings</u>		

**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 Lindell Jarman

Licensed Embalmer No. 4589  
P.O. Address Excelsior Springs

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.