

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041640

STATE FILE NUMBER

Registration District No. 386 Primary Registration District No. 3097 Registrar's No. 602

AMENDED

FILED DEC 4 1961

1. PLACE OF DEATH a. COUNTY <u>Linn</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marceline</u> Length of stay in 1b <u>6 Years</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bunton Rest Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Chariton</u> c. CITY OR TOWN <u>Triplet</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1 Mi. East</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Florilla</u> Middle <u>E.</u> Last <u>Duffield</u>			4. DATE OF DEATH Month <u>11</u> Day <u>21</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>11-5-1874</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>	
10c. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Jacob Lippencot</u>		13b. MOTHER'S MAIDEN NAME <u>Lucinda Davis</u>	
14. NAME OF HUSBAND OR WIFE <u> </u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>J. Duffield</u> Address <u>Triplet Mo.</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>Cerebral Vascular Accident, old, 4 new approx 2 wks</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis with</u> DUE TO (c) <u>A.S.A.D</u>			
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.)			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> 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 <u>11-16-61</u> , to <u> </u> , and last saw <u>her</u> alive on <u>11-16-61</u> Death occurred at <u>11-21-61</u> <u>7:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Blasmon A. Humer, M.D.</u>			22b. ADDRESS <u>Marceline, Mo</u>		22c. DATE SIGNED <u>11-24-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-24-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>McCullough</u>		23d. LOCATION (City, town, or county) (State) <u>Triplet, Mo.</u>	
24. FUNERAL DIRECTOR <u>L.E. McCurry</u> ADDRESS <u>Brunswick Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-24-1961</u>		26. REGISTRAR'S SIGNATURE <u>Anna Watson</u>	

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

L. E. McGary

Licensed Embalmer No.

4806

P. O. Address

Brienswick

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.