SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

-61-043531

STATE FILE NUMBER

AMENDED

Registration District No. 15 Primary Registration District No. 3004 Registrar's No. 107

FILED JAN 2 1962

1. PLACE OF DEATH
a. COUNTY Barton
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lamar — Length of stay in 1b: 1 day
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Barton Co. Mem. Hosp. — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri COUNTY Dade
c. CITY OR TOWN Lockwood — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) Good Shepherd Nursing Home — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: BLANCHE Middle: RUBY Last: HUGHES
4. DATE OF DEATH Month: December Day: 17 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 1-1-1879
9. AGE (last birthday): 82
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (City and state or country): Barton Co., Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: William McFarland
13b. MOTHER'S MAIDEN NAME: Ann Jane Graham
14. NAME OF HUSBAND OR WIFE: Rolla J. Hughes
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.: --
17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
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): Generalized Arteriosclerosis – Debility of Old Age
PART III. If deceased was female was there a pregnancy in last 90 days? ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 12/16/61 to 12/17/61 and last saw her alive on 12/17/61
Death occurred at 4:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE Thomas S. Carroll (Degree or title) M.D.
22b. ADDRESS 1204 Bell St Sted – Lamar Mo
22c. DATE SIGNED 12/18/61
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 12/21/61
23c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery
23d. LOCATION (City, town, or county) (State): Golden City, Mo.
24. FUNERAL DIRECTOR ADDRESS: Phillips Funeral Home, Golden City, Mo.
25. DATE RECD. BY LOCAL REG.: DEC 27 '61
26. REGISTRAR'S SIGNATURE: Marie Koranda

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED — INSTEAD OF — SHOULD READ — ITEM NO. — DOCUMENT — BY AFFIDAVIT OF

JAN 5 1962

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 3278

P. O. Address Golden City

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.