

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043839

AMENDED

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 484 STATE FILE NUMBER

FILED DEC 26 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Cape Girardeau</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>	a. STATE <u>Missouri</u>	b. COUNTY <u>Cape Girardeau</u>
Length of stay in 1b <u>30 days</u>		c. CITY OR TOWN <u>Jackson</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Francis Hospital</u>		d. STREET ADDRESS <u>3 miles E of Jackson</u>	(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Carrie</u>	Middle <u>Brown</u>	Last <u>Lacey</u>	4. DATE OF DEATH	Month <u>Dec</u>	Day <u>16</u>	Year <u>1961</u>
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5. SEX <u>F</u>	6. COLOR OR RACE <u>negro</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>10/27/1884</u>	9. AGE (last birthday) <u>77</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>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Oak Ridge, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Charlie Brown</u>	13b. MOTHER'S MAIDEN NAME <u>Louise Day</u>	14. NAME OF HUSBAND OR WIFE <u>Alphonso Lacey</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <u>no</u> or unknown)	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Address <u>Mrs. Louise King Jackson, 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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Carcinoma colon - metastases</u>		<u>?</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hepatic coma</u>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized Arteriosclerosis</u>		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.)
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20c. TIME OF INJURY	Hour <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year <u></u>
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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
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21. I attended the deceased from Nov 18, 1961 to Dec 16, 1961 and last saw her alive on Dec 16, 1961
 Death occurred at 8:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Joseph E. Necker M.D.</u> (Degree or title)	22b. ADDRESS <u>Jackson, Mo.</u>	22c. DATE SIGNED <u>Dec 19 1961</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>Dec 20, 1961</u>	23c. NAME OF CEMETERY OR CREMATOR <u>Russell Heights</u>	23d. LOCATION (City, town, or county) <u>Jackson</u>	23e. STATE <u>Missouri</u>
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24. FUNERAL DIRECTOR <u>H.C. Cravens</u> ADDRESS <u>Jackson, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-20-61</u>	26. REGISTRAR'S SIGNATURE <u>James Kasten</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 *H. C. Crawford*

Licensed Embalmer No. 437

P. O. Address Jackson, ?

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.