

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

46 -61-045402  
STATE FILE NUMBER

AMENDED

Registration District No. 171 Primary Registration District No. 4267 Registrar's No. 38

**FILED DEC 28 1961**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Lafayette</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Odessa, Mo.</u>	a. STATE <u>Mo.</u>	b. COUNTY <u>Lafayette</u>
Length of stay in 1b <u>60 Yrs.</u>		c. CITY OR TOWN <u>Odessa</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		d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Clarence</u>	Middle <u>Gant</u>	Last	4. DATE OF DEATH	Month <u>Dec.</u>	Day <u>14,</u>	Year <u>1961</u>
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5. SEX <u>Male</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>12-15-85</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired R. R. worker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u>	11. BIRTHPLACE (City and state or country) <u>Lafayette Co, Mo.</u>	12. CITIZEN OF WHAT COUNTRY
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13a. FATHER'S NAME <u>Charles Gant</u>	13b. MOTHER'S MAIDEN NAME <u>Ellen Conaway</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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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 <u>Hugh Gant,</u>	Address <u>Higginsville, M.</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>① malnutrition</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) <u>② alcoholism</u>	
DUE TO (c) <u>③ Smility</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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 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 Nov 1-61 to Dec 14-61 and last saw <sup>her</sup>him alive on Dec 14-61  
Death occurred at 12<sup>30</sup>/<sub>2</sub> AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W. Martin MD</u>	(Degree or title)	22b. ADDRESS <u>Odessa Mo</u>	22c. DATE SIGNED <u>12-16-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec. 16, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Odessa Cemetery</u>	23d. LOCATION (City, town, or county) <u>Odessa, Mo.</u>
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24. FUNERAL DIRECTOR <u>Husman-Sparks,</u>	ADDRESS <u>Odessa, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-16-1961</u>	26. REGISTRAR'S SIGNATURE <u>Emma Davidson</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

DEC. 29 1961

MAR 13 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 \_\_\_\_\_

Signature of Student Embalmer

Signed

*William F. Sparks*

Licensed Embalmer No. 4431

P. O. Address Olena, W.

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.