

# MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-047638  
STATE FILE NUMBER

AMENDED

Registration District No. 333 Primary Registration District No. 45-45 Registrar's No. 7

**FILED JAN 15 1962**

1. PLACE OF DEATH a. COUNTY <b>WEBSTER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>WEBSTER</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MARSHFIELD</b>		c. CITY OR TOWN <b>MARSHFIELD MO</b>	
Length of stay in 1b <b>1 WK</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) <b>9 MI SOUTH WEST</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>LAWRENCE C CHOUSE</b>			4. DATE OF DEATH Month Day Year <b>DEC 29 1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-8-1896</b>	9. AGE (last birthday) <b>65</b>	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) <b>RET FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>
13a. FATHER'S NAME <b>GEORGE CHOUSE</b>		13b. MOTHER'S MAIDEN NAME <b>TILDA STONE</b>		14. NAME OF SPOUSE OR WIFE <b>LETHA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>LETHA CHOUSE MARSHFIELD MO</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute</b>		INTERVAL BETWEEN ONSET AND DEATH <b>29 min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Dissecting aortic aneurysm, retrograde to involve the coronary ostia, recurrent. 29-</b>	
	DUE TO (c) <b>(1st attack May 1960)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertensive C.-V. disease</b>		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 . Month, Day, Year a.m. p.m.			
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 4/24/57 to 12/29/61 and last saw him alive on 12/29/61  
Death occurred at 9:09 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>J. M. McDonnell MD.</b>		22b. ADDRESS <b>marshfield, Mo.</b>		22c. DATE SIGNED <b>1/9/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>12-31-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT OLIVE</b>		23d. LOCATION (City, town, or county) (State) <b>WEBSTER CO MO</b>
24. FUNERAL DIRECTOR ADDRESS <b>BARBER-EDWARDS MARSHFIELD</b>		25. DATE RECD. BY LOCAL REG. <b>1-8-62</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

DATE ATTENDED BY 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 Bernie Stoffe

Licensed Embalmer No. 3161

P. O. Address W. A. Perry

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.