

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-007199

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 289 Primary Registration District No. \_\_\_\_\_ Registrar's No. 6

AMENDED

**FILED MAR 7 1962**

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lewis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Palmyra</u>		c. CITY OR TOWN <u>La Grange Mo</u>	
Length of stay in 1b _____		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Maple Lawn Rest Home</u>		d. STREET ADDRESS (If outside, give location) <u>No street address</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Lula Belle Ford</u>			4. DATE OF DEATH Month Day Year <u>February 10 - 1962</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>5-14-1895</u>	9. AGE (last birthday) <u>86</u>	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) <u>house wife</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Napoleon, Ky.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---------------------------------------------------------------------------------------------------------------	-----------------------------------------	-----------------------------------------------------------------	-------------------------------------------

13a. FATHER'S NAME <u>Joseph Hillard</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Frances Landrum</u>	14. NAME OF HUSBAND OR WIFE <u>Joseph Ford</u>
------------------------------------------	-------------------------------------------------------	------------------------------------------------

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 Address <u>Mrs. Nettie Zahn Canton, 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>Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Myocardial</u>		
DUE TO (c) <u>I.B. pneumonia</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 a.m. _____ p.m. _____ Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>Sept 30, 1961</u> to <u>Feb 10, 1962</u> and last saw her alive on <u>Feb 10, 1962</u> Death occurred at <u>5:45 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

22a. SIGNATURE (Degree or title) <u>W. E. Elmer M.D.</u>	22b. ADDRESS <u>La Grange Mo</u>	22c. DATE SIGNED _____
----------------------------------------------------------	----------------------------------	------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-13-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>River View Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>La Grange Mo.</u>
---------------------------------------------------------	----------------------------	---------------------------------------------------------------	--------------------------------------------------------------------

24. FUNERAL DIRECTOR ADDRESS <u>J. Kenneth Bailey La Grange, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>2-28-62</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke</u> <u>By Viola Lee, Deputy</u>
----------------------------------------------------------------------	---------------------------------------------	---------------------------------------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 ITEM NO. SHOULD READ  
 BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

JUL 10 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

*J. Kenneth Baskin*

Licensed Embalmer No. 4245

P. O. Address La Grange, Ill.

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.