

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-013969

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 115

FILED APR 23 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

MEDICAL CERTIFICATE APPENDIX

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkville,</u>		Length of stay in 1b <u>years</u>	c. CITY OR TOWN <u>Kirkville,</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <del>X HOSPITAL</del> <del>X NURSING HOME</del> <u>Nursing Home # 1</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1608 S. Osteopathy</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELSIE LOURANCE GREEN</u>			4. DATE OF DEATH Month Day Year <u>April 14 1962</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. <del>Married</del> <input type="checkbox"/> <del>Never Married</del> <input checked="" type="checkbox"/> <del>Widowed</del> <input checked="" type="checkbox"/> <del>Divorced</del> <input type="checkbox"/>	8. DATE OF BIRTH <u>11/13/80</u>
9. AGE (last birthday) <u>81</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>Home Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Danville, Illinois</u>
12. CITIZEN OF WHAT COUNTRY <u>U S</u>		13a. FATHER'S NAME <u>Arthur Lourance</u>	
13b. MOTHER'S MAIDEN NAME <u>Margret Lourance</u>		14. NAME OF HUSBAND <del>OR WIFE</del> <u>Joseph Green</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 <u>Ocie Yadon, Kirkville, Mo.</u> Address
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>Medullary failure</u>			<u>5-min</u>
DUE TO (b) <u>Pulmonary congestion</u>			<u>7-10 days</u>
DUE TO (c) <u>Lobar pneumonia</u>			<u>7-10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus</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.)			
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 <u>3-27-59</u> to <u>4-14-62</u> and last saw her alive on _____ Death occurred at <u>5:05</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (I) <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>800 W. Jefferson, Kirkville</u>	22c. DATE SIGNED <u>4/16/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Apr. 16-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Novinger</u>	23d. LOCATION (City, town, or county) (State) <u>Novinger, Adair, Mo.</u>
24. FUNERAL DIRECTOR <u>Foster Memorial Home, Kirkville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>April 16, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Doris W. Ratliff</u>

USE BLACK INK OR TYPEWRITER RIBBON

Permit issued April 16, 1962

D. E. Maddox, D.O., Assistant

**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 \_\_\_\_\_  
Nova E. Foster

Licensed Embalmer No. 4742

P. O. Address Kirksville, Mo.

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.