

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-017716

Registration District No. 340 Primary Registration District No. 4503 Registrar's No. 41

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 3 1962	
1. PLACE OF DEATH a. COUNTY <u>Stoddard</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bernie Liberty</u> Length of stay in 1b <u>Years</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Family residence</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u> c. CITY OR TOWN <u>Bernie</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>East Side</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Thomas Lancaster</u>	
4. DATE OF DEATH Month Day Year <u>April 18, 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-25-1877</u>
9. AGE (last birthday) <u>85</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>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>
11. BIRTHPLACE (City and state or country) <u>Bernie, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>William Lancaster</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Deason</u>
14. NAME OF HUSBAND OR WIFE <u>Ruth Glass Lancaster</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>Mrs. A.N. Hendley Rt. 1 Bernie, Mo.</u> Address	
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>Disease of the Coronary Arteries</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>Mar. 26, 1962</u> to <u>Apr. 13, 1962</u> and last saw ^{her} him alive on <u>Apr. 13, 1962</u> . Death occurred at <u>5:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>F. O. Kelley D.O.</u> (Degree or title)	22b. ADDRESS <u>Bernie, Mo.</u>
22c. DATE SIGNED <u>4-21-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-20-62</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Bernie Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Bernie, Missouri</u>
24. FUNERAL DIRECTOR <u>Duffie-Hainey</u> ADDRESS <u>Bernie, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4/28-62</u>
26. REGISTRAR'S SIGNATURE <u>Velma V. Jenkins</u>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

MAY 4 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 Raymond L. Duffie

Licensed Embalmer No. 4798

P. O. Address Bernie, 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.