

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-039922

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 442

FILED OCT 24 1962

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| 1. PLACE OF DEATH a. COUNTY <u>St. Francois</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u> Length of stay in 1b <u>5 Days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bonne Terre Hosp.</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>St. Francois</u> c. CITY OR TOWN <u>Flat River</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
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| 3. NAME OF DECEASED (Type or print) First <u>Elizbeth</u> Middle <u>Laird</u> Last <u>Laird</u> | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>17,</u> Year <u>1962</u> | | | | | |
| 5. SEX <u>Female</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>5/30/1876</u> | 9. AGE (last birthday) <u>86</u> | IF UNDER 1 YEAR Months <u>4</u> Days <u>17</u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | | 11. BIRTHPLACE (City and state or country) <u>Texas</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | |
| 13a. FATHER'S NAME <u>Unknown</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | 14. NAME OF HUSBAND OR WIFE <u>J. C. Laird</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 Address <u>Mrs. Wayne Howlett Flat River, Mo.</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: IMMEDIATE CAUSE (a) <u>MESENTERIC Thrombosis (suspected)</u> DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> |
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| 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 <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u> | | 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 6-14-61 to 10-17-62 and last saw her alive on 10-17-62
 Death occurred at 7:50 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>C. E. Conleton, M.D.</u> | 22b. ADDRESS <u>Farmington, Mo.</u> | 22c. DATE SIGNED <u>10/19/62</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>10/20/1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Parkview Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Farmington, Mo.</u> |
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| 24. FUNERAL DIRECTOR ADDRESS <u>Murphy L. Sparks Flat River, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>Oct 19, 1962</u> | 26. REGISTRAR'S SIGNATURE <u>Ethel Rudloff</u> |
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(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

1 0941

2 0942

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9 4500

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

6-21-1950

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 *Murphy*

Licensed Embalmer No. 4256

P. O. Address *Hadwin*

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.