

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-001350

AMENDED

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 11

STATE FILE NUMBER

FILED JAN 15 1962

|   |  |   |  |  |  |  |   |
|---|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)        |  |  |   |
| a. COUNTY <u>HENRY</u>  |  |   |  | a. STATE <u>Mo</u>   |  | b. COUNTY <u>HENRY</u>   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Clinton Mo</u>  |  | Length of stay in lb<br><u>no</u>   |  | c. CITY OR TOWN <u>Clinton Mo</u>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Home #52 Hwy North</u>  |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  | d. STREET ADDRESS (If outside, give location)<br><u>#52 Hwy North</u>  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>W. D DeLozier</u>  |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>JAN 11 1962</u>                                     |  |  |   |
| 5. SEX<br><u>male</u>   | 6. COLOR OR RACE<br><u>white</u>       | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>July 21, 1883</u>   | 9. AGE (last birthday)<br><u>78</u>  | IF UNDER 1 YEAR<br>Months <u>5</u> Days <u>21</u> Hours <u>-</u> Min <u>-</u>        | IF UNDER 24 HR<br>Hours <u>-</u> Min <u>-</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Implement Dealer</u>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Retired</u>                                  |  | 11. BIRTHPLACE (City and state or country)<br><u>Henry County U.S.A</u>  |  | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A</u>   |
| 13a. FATHER'S NAME<br><u>James Edward DeLozier</u>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Alabama Julia</u>                                    |  | 14. NAME OF HUSBAND OR WIFE<br><u>JOANNA Briggs DeLozier</u>   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>   |  | 16. SOCIAL SECURITY NO.<br><u>493-383381</u>  |  | 17. INFORMANT<br><u>Mrs JOANNA DeLozier, Clinton Mo</u>                                      |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 weeks</u>                                    |
| IMMEDIATE CAUSE (a) <u>Uremic Encephalopathy</u>  |  |   | DUE TO (b) <u>Prostatic Carcinoma</u>  |  |  |  | DUE TO (c) <u>4 mo.</u>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |  |   |  |  |  |  |   |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input 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<br>Hour a.m. p.m.<br>Month, Day, Year   |  |   |  |  |  |  |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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>11-11-61</u> , to <u>1-7-62</u> and last saw <sup>her</sup> him alive on <u>1-7-62</u> .<br>Death occurred at <u>6:15 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |  |  |  |   |
| 22a. SIGNATURE (Degree or title)<br><u>W.A. Bradshaw, M.D.</u>  |  |   |  | 22b. ADDRESS<br><u>Clinton, Mo.</u>  |  | 22c. DATE SIGNED<br><u>1-12-62</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |  | 23b. DATE<br><u>JAN 13-1962</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Englewood</u>                               |  | 23d. LOCATION (City, town, or county)<br><u>Clinton Mo</u>   |  | (State)   |
| 24. FUNERAL DIRECTOR<br><u>E.L. Schaberg</u>  |  |   | ADDRESS<br><u>214 So. 2nd Clinton Mo</u>   |  | 25. DATE RECD. BY LOCAL REG.<br><u>JAN. 13-1962</u>  | 26. REGISTRAR'S SIGNATURE<br><u>Mildred Bigum</u>                                    |   |

(Licensed Embalmer's Statement on Reverse Side)

By J.M.P.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 A. A. Kenney

Licensed Embalmer No. 3099

P. O. Address Clinton 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.