

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0001250

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 137

Primary Registration District No. 3023

Registrar's No. 23

FILED 27 64

VS 300
Rev. 4/59

10425
20425

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4 1
5 1
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7 0
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9 331 X

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13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT

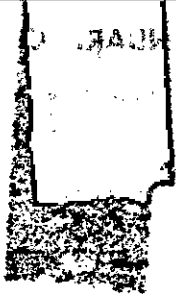
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u>	
b. CITY (if outside corporate limits, give TOWNSHIP, only) OR TOWN <u>Clinton</u>		c. CITY OR TOWN <u>Clinton</u> 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>Clinton Gen. Hosp.</u>		d. STREET ADDRESS (if outside, give location) <u>409 West Short</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LULA - MARTIN</u>			4. DATE OF DEATH Month Day Year <u>Jan. 23 1964</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>5-20-1889</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>none</u>	11. BIRTHPLACE (City and state or country) <u>Drew Mo.</u>
13a. FATHER'S NAME <u>Wm Thomas</u>		13b. MOTHER'S MAIDEN NAME <u>Arsenath Grimes Lewis Martin</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>?</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>cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		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	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
19. WAS AUTOPSY PERFORMED? 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 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>1955</u> to <u>1-23-64</u> and last saw ^{her} _{him} alive on <u>1-23-64</u> Death occurred at <u>9:45</u> <u>A</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Hugh B. Walker, MD</u>		22b. ADDRESS <u>Clinton, Mo.</u>	
		22c. DATE SIGNED <u>1-24-64</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-25-64</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Englewood</u>	23d. LOCATION (City, town, or county) (State) <u>Clinton Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>F.L. SCHABER 9 CLINTON, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 24, 1964</u>	
26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>			

USE BLACK INK OR TYPEWRITER RIBBON

20100



STATEMENT BY LICENSED EMBALMER

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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 F L Schaberg

Licensed Embalmer No. 4513

P. O. Address Cleaton 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.

Permit Obtained 1-24-64
M.S.