

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

0013751

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 032 Primary Registration District No. 4042 Registrar's No. 26 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

APPELLED 2064

1. PLACE OF DEATH a. COUNTY <u>BOLLINGER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>BOLLINGER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LUTESVILLE</u>		Length of stay in 1b <u>2 mo.</u>	c. CITY OR TOWN <u>LUTESVILLE</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>WAYVIL Nursing Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>ROYAL</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>LAWSON A DARNELL</u>			4. DATE OF DEATH Month Day Year <u>APRIL 10 1964</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 9 1875</u>	9. AGE (last birthday) <u>88</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>MINISTER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>DONIPHAN, MO</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>WM. DARNELL</u>		13b. MOTHER'S MAIDEN NAME <u>JANE GLENN</u>	
14. NAME OF HUSBAND OR WIFE <u>IDA BELLE WRIGHT</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>64-944-983</u>	
17. INFORMANT <u>C. E. Darnell, Brighton, MO</u>		Address		Interval BETWEEN ONSET AND DEATH	

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>Acute congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis.</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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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>4-63</u> to <u>4-10-64</u> and last saw ^{her} _{him} alive on <u>4-10-64</u> Death occurred at <u>7:00 A.M.</u> m on the date stated above and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>John W. Englehart MD</u> (Degree or title)	22b. ADDRESS <u>Lutesville, Mo.</u>	22c. DATE SIGNED <u>4-13-64</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4-12-64</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GLEN ALLEN Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>GLEN ALLEN, MO</u>
24. FUNERAL DIRECTOR <u>Gene Ward, Lutesville, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4/15/64</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Buford Craden</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59
10090
20090
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9 4:00
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To be filled in

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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 *Samuel Riley*
Student Embalmer No. _____

Licensed Embalmer No. 5086
P. O. Address *Rutland, 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.