

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014569

STATE FILE NUMBER

FILED MAY 11 1959 Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 180

1. PLACE OF DEATH a. COUNTY <u>St Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St Francois</u>	
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) <u>BONNE TERRE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ESTHER 0940</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>BONNE TERRE</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>LEROY</u> Middle <u>HOWARD</u> Last <u>LARKIN</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>28</u> Year <u>1959</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>Nov. 27, 1916</u>	9. AGE (In years last birthday) <u>42</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>FARM IMPLEMENT</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>ESTHER, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>RAY LARKIN</u>	13b. MOTHER'S MAIDEN NAME <u>CORA HARRIS</u>	14. NAME OF DECEASED OR WIFE <u>AMY LARKIN</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>497-02-8580</u>	17. INFORMANT <u>AMY LARKIN, Esther, 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>Infarction of myocardium</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>		<u>4 yrs.</u>
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>		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 _____ Month, Day, Year _____ a.m. _____ p.m. _____	

20d. INJURY OCCURRED WHILE AT <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 <u>Bonne Terre, Mo.</u>	COUNTY _____ STATE _____
21. I attended the deceased from <u>Nov., 1957</u> to <u>April 28, 1959</u> and last saw ^{her} him alive on <u>April 28, 1959</u> Death occurred at <u>4:20</u> P.m. on the date stated above; and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <u>5/4/59</u>	
22a. SIGNATURE <u>John W. Fuller MD</u> (Deceased or title)		22b. ADDRESS <u>Bonne Terre, Mo.</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAY 4, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. FRANS MEM. PARK</u>	23d. LOCATION (City, town, or county) (State) <u>Bonne Terre, Mo.</u>
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24. FUNERAL DIRECTOR <u>Raymond Caldwell Ordone</u> ADDRESS <u>Flat River, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>May 8, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Eather Rudloff</u>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

FEB 26 1960

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 R. Caldwell

Licensed Embalmer No. 2531

P. O. Address Flat RWS,

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.