

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 346 Primary Registration District No. 3061 Registrar's No. 0007732

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

USE BLACK INK  
OR  
TYPEWRITER RIBBON

BY AFFIDAVIT OF  
MEDICAL CERTIFICATION  
DOCUMENT

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Francois</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> COUNTY <b>St. Francois</b>                |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Flat River</b>  |   | Length of stay in 1b  | c. CITY OR TOWN <b>Flat River</b>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>310 Glendale</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>310 Glendale</b>  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>LAVADA PEARL DAUGHERTY</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>Feb. 27, 1964</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 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><b>2/25/1905</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Shoe worker</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (last birthday)<br><b>59</b>   |
| 11a. BIRTHPLACE (City and state or country)<br><b>St. Francois</b>  |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |   |
| 13a. FATHER'S NAME<br><b>Patrick Henry Gibson</b>   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Margaret Williams</b>   | 14. NAME OF HUSBAND OR WIFE<br><b>Ernie Daugherty</b>   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |   | 16. SOCIAL SECURITY NO.<br><b>500-16-2726</b>   | 17. INFORMANT Address<br><b>Ernie Daugherty Flat River, Mo</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Lymphosarcoma</b>  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 months</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c)  |   |   |   |
| 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.<br>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 <b>5-15-64</b> to <b>2-27-64</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>2-24-64</b><br>Death occurred at <b>7:01 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |
| 22a. SIGNATURE (Degree or title)<br><i>[Signature]</i>  |   | 22b. ADDRESS<br><b>Bonne Terre, Mo</b>  | 22c. DATE SIGNED<br><b>2/29/64</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>3/1/1964</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Three Rivers</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>St. Francois Co. Mo.</b>  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Murphy L. Sparks Flat River, Mo</b>  |   | 25. DATE RECD. BY LOCAL REG.<br><b>Feb. 29 1964</b>   | 26. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |

0001125

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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 Murphy Sparks

Licensed Embalmer No. 4254

P. O. Address 1401 1/2 St. W. No

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.

20/01/3