

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041129

STATE FILE NUMBER

FILED DEC 2 1958

Registration District No. 4448

Primary Registration District No. 6024

Registrar's No. 126

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Ray</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lawson</u>		c. CITY OR TOWN <u>Lawson</u> 0890	
c. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
Length of stay in 1b <u>37 years</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>RAYMOND ALPHONSO ROCK</u>			4. DATE OF DEATH Month Day Year <u>Nov. 18. 1958</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>Sept 16, 1884</u>	9. AGE (in years last birthday) <u>74</u>	IF UNDER 1 YEAR Months Days <u>2 2</u>	IF UNDER 24 HRS. Hours Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurateur</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Andrew A. Rock</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Williams</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Eva Rock</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>488-22-6924</u>		17. INFORMANT <u>Mrs. Eva Rock Lawson 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>Pulmonary edema & Cardiac failure</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>Herpes zoster & maresmns</u>			3 wks.		
DUE TO (c)					
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 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.) <u>088X</u>		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					

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.) <u>Lawson</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Ray Mo.</u>	
21. I attended the deceased from <u>Oct. 15, 1958</u> to <u>Nov. 18, 1958</u> and last saw ^{him} alive on <u>Nov. 18, 1958</u> . Death occurred at <u>9:30 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE (Degree or title) <u>Arthur Buehner M.D.</u>			22b. ADDRESS <u>Lawson Mo.</u>		22c. DATE SIGNED <u>11/19/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 21 '58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lawson Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Lawson Mo</u>
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24. FUNERAL DIRECTOR <u>Jimmie Funeral Home</u>		ADDRESS <u>Lawson</u>	25. DATE RECD. BY LOCAL REG. <u>11-25-1958</u>	26. REGISTRAR'S SIGNATURE <u>Malcol Jackson</u>	
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related. Secondary diseases may be stated in Part II if they do not have symptoms which are listed.

DEC 12 1958

DEC 19 1958

DEC 15 1958

DEC 4 1958

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 *Lindell Jarman*

Licensed Embalmer No. *4589*
P. O. Address *Excelsior Springs, 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.