

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **674**

BIRTH NO. _____ REG. DIST. NO. **96** PRIMARY REG. DIST. NO. **5354** Registrar's No. **7**

0300

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Dallas | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Dallas | |
| b. CITY (If outside corporate limits, write RURAL and give township) Red Top Rural | | c. CITY (If outside corporate limits, write RURAL and give township) Red Top Rural | |
| c. LENGTH OF STAY (If this place) | | d. STREET ADDRESS (If rural, give location) | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | | |

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|--|--------------------------|-------------------------|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) LEWIS | b. (Middle) FLOYD | c. (Last) LUCCAS | 4. DATE OF DEATH. (Month) (Day) (Year) Jan-3-1954 |
|--|--------------------------|-------------------------|---|

| | | | | | | |
|--------------------|-------------------------------|--|--------------------------------------|---|---|--------------------------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 10-3-1888 | 9. AGE (In years last birthday) 62 | IF UNDER 1 YEAR Months 3 Days 0 | IF UNDER 24 HRS. Hours 0 Min. |
|--------------------|-------------------------------|--|--------------------------------------|---|---|--------------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filling Station | 10b. KIND OF BUSINESS OR INDUSTRY gas station | 11. BIRTHPLACE (State or foreign country) Missouri | 12. CITIZEN OF WHAT COUNTRY? USA |
|---|---|--|--|

| | | |
|--|---|--|
| 13a. FATHER'S NAME Bud Force | 13b. MOTHER'S MAIDEN NAME Bell McCumy | 14. NAME OF HUSBAND OR WIFE Florence |
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|---|-------------------------|--|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME Florence | ADDRESS |
|---|-------------------------|--|---------|

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|---|---|--|---|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 163x |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Right Bronchus | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

| | | |
|------------------------|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION As above | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|---|---|

| | | |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
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| | | |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from **4-24**, 19**50**, to **1-3**, 19**51**, that I last saw the deceased alive on **6-26**, 19**50**, and that death occurred at _____ m., from the causes and on the date stated above.

| | | | |
|---------------------------------------|----------------------------------|---------------------------------------|------------------------------------|
| 23a. SIGNATURE May J. Fitch | (Degree or title) M.D. | 23b. ADDRESS Springfield Mo | 23c. DATE SIGNED 1-10-51 |
|---------------------------------------|----------------------------------|---------------------------------------|------------------------------------|

| | | | |
|--|------------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 1-5-1954 | 24c. NAME OF CEMETERY OR CREMATORY Union Grove | 24d. LOCATION (City, town, or county) (State) Dallas Co Mo |
|--|------------------------------|--|--|

| | | | |
|--|---|--|------------------------------|
| DATE REC'D BY LOCAL REG. 1/13/51 | REGISTRAR'S SIGNATURE Dr. J. B. Jones | 25. FUNERAL DIRECTOR'S SIGNATURE L. B. Jones | ADDRESS Buffalo Mo |
|--|---|--|------------------------------|

Date Filed 1-16-51
1-15-51
JAN 16 1951
Springfield
HEALTH DEPT. MO.

JAN 22 1951

JAN 21 1951

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 _____

working under my personal supervision.

Student Embalmer No.

Signed

Edward B. Jones

Signed.....
Student Embalmer

Licensed Embalmer No. 5508

P. O. Address Buffalo 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 this body is not embalmed, fact should be so stated above.