

FILED JUL 18 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **22242**  
Registrar's No. **2791**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived) If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Sullivan</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City Mo</b>	c. LENGTH OF STAY (If this place) <b>8 days</b>	c. CITY OR TOWN <b>Milan</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>		STREET ADDRESS (If rural, give location) <b>1050</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>John</b> b. (Middle) <b>William</b> c. (Last) <b>Lee</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>7 1 58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>12-22-89</b>	9. AGE (In years last birthday) <b>65</b>	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) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Sullivan Co. Mo</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					

13a. FATHER'S NAME <b>James W Lee</b>		13b. MOTHER'S MAIDEN NAME <b>Lovelyn Hayes</b>		14. NAME OF HUSBAND OR WIFE <b>Myrtle Mae Lee</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>49890-8719</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Myrtle Mae Lee - Milan Mo</b>	

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, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Lung, Primary</b>		INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbidity 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. <b>Emphysema; Atelectasis right lung</b>		<b>16 1/2</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPEY? YES <input checked="" type="checkbox"/> NO <input 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <b>David M. Gibson</b> (Degree or title) <b>David M. Gibson M.D. (Pathologist)</b>		23b. ADDRESS <b>St. Luke's Hospital K.C. Mo.</b>		23c. DATE SIGNED <b>7/1/55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>July 1-1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Milan, Missouri</b>	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wm. C. P. Foster, Funeral Home K.C. Mo</b>			
DATE REC'D BY LOCAL REG. <b>7-1-55</b>		REGISTRAR'S SIGNATURE <b>Neval Marshall</b>			

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

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 *J. W. H. Henrich*.....  
Licensed Embalmer No. *359*

P. O. Address *J. C. M. D.*

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.