

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

57-0-22418
STATE FILE NUMBER
318 1003 5645

FILED JUN 25 1957

Registration District No. Primary Registration District No. Registrar's No.

Health, Welfare, Public Service
000-56
No symptoms will be listed. Carer cannot certify to a death due to natural causes. Diseases in Part I must be casually related. Carer cannot certify to a death due to natural causes. Carer cannot certify to a death due to natural causes.

1. PLACE OF DEATH a. COUNTY <u>St. Louis, Mo</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illin</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Granite City</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>Mo-Pac-Hosp</u>			Length of stay in lb <u>19 days</u>	32. STREET ADDRESS <u>2514 Iowa</u>	
3. NAME OF DECEASED (Type or print) First <u>Lee</u> Middle <u>Mourer</u> Last <u>Chase</u>			4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1957</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>Aug. 11, 1901</u>	9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Rail-Road</u>	11. BIRTHPLACE (City and state or country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>George T. Chase</u>			14. MOTHER'S MAIDEN NAME <u>Pearl Harlan</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>702-09-1233</u>	17. INFORMANT <u>Dorothy Chase</u> Address <u>Granite City, Ill.</u>		
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>Carcinoma of Lung (Bronchogenic) - squamous cell carcinoma</u>					INTERVAL BETWEEN ONSET AND DEATH <u>about 6 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>162x</u>					
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 checked="" type="checkbox"/> NO <input 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 _____ 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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE	
21. I attended the deceased from <u>March 1957</u> to <u>June 15, 1957</u> and last saw <u>him</u> alive on <u>June 14, 1957</u> . Death occurred at <u>10:40 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Benjamin H. Clark, M.D.</u> (Degree or title)			22b. ADDRESS <u>Mo. Pac. Hospital - 566 Olive</u>		22c. DATE SIGNED <u>June 18, 1957</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>June 17</u>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <u>Granite City, Illinois</u>	
24. FUNERAL DIRECTOR <u>Hodge</u> ADDRESS <u>Granite City, Illinois</u>		25. DATE RECD. BY LOCAL REG. <u>JUN 17 '57</u>	26. REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Handwritten notes at the top of the page, including "all records" and "yes to" followed by illegible scribbles.

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 *Harvey Stahl*
Licensed Embalmer No. *45*

P. O. Address *Flournoy*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.