

Health, Welfare, Public Service

FILED SEP 23 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30815
STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 844

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		c. CITY OR TOWN <u>Hallsville</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>U. of Mo. Med Center</u>		d. STREET ADDRESS (If outside, give location) <u>Route 1</u>	
Length of stay in lb <u>21 da 6 hrs</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence Johannes Jensen</u>			4. DATE OF DEATH Month Day Year <u>Sept. 16, 1957</u>		
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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>3-13-00</u>	9. AGE (in years last birthday) <u>57</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>HERMAN, Neb.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Jens Peter Jensen</u>	13b. MOTHER'S MAIDEN NAME <u>ANNA HANSEN</u>	14. NAME OF HUSBAND OR WIFE <u>Florence Jensen</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT <u>Hospital Chart</u>	Address
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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>Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>debilitation from disseminated lymphosarcoma</u>	<u>2 years.</u>
	DUE TO (c) <u>200.1</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Rheumatoid Arthritis</u>		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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from <u>8-27-57</u> to <u>9-16-57</u> and last saw ^{him} alive on <u>9-16-57</u> Death occurred at <u>8:20 PM</u> m on the date stated above; and to the best of my knowledge, from the cause stated.

22a. SIGNATURE <u>Diana Burkhardt, M.D.</u>	22b. ADDRESS <u>U. of Missouri Medical Center</u>	22c. DATE SIGNED <u>9-17-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/19/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>TEKAMAH Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Tekamah Nebraska</u>
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24. FUNERAL DIRECTOR <u>Bill Meador, Centralia, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Sept 17 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palomer</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

ALL CAUSES MUST BE CAUSALLY RELATED.

SEP 24 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~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Ernest H. Spunkle*

Licensed Embalmer No. *4013*
P. O. Address *Columbia, Md.*

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.