

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008683
STATE FILE NUMBER

FILED APR 7 1958

Registration District No. 2 Primary Registration District No. 4008 Registrar's No. 22

1. PLACE OF DEATH a. COUNTY <u>Andrew</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cosby</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Cosby</u> <u>0020</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Length of stay in 1b <u>10yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>Home</u>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>C.</u> Last <u>Lamar</u>			4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 5, 1871</u>
9a. AGE (In years last birthday) <u>86</u>		9b. F UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	9c. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>he. Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>New Market, Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Thomas Lamar</u>	
13b. MOTHER'S MAIDEN NAME <u>Sarah Jane Bush</u>		14. NAME OF HUSBAND OR WIFE <u>Nettie(de)</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>none</u>	17. INFORMANT <u>Thomas Lamar Maryville, Mo</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>Suffocation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Smoke inhalation</u>			<u>minutes</u>
DUE TO (c) <u>Residential conflagration</u>			<u>9160/16</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>First and second degree burns, entire body</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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>Fuel oil in space heater exploded, burning deceased</u>	
20c. TIME OF INJURY <u>6:30 p.m. 3/20/58</u>		<u>and setting home afire.</u> <u>002</u>	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home.</u>	20f. CITY, TOWN, OR LOCATION <u>Cosby</u>
		COUNTY <u>Andrew</u>	STATE <u>Mo.</u>
21. I attended the deceased from <u>Sept., 1943</u> to <u>March 20, 1958</u> and last saw ^{him} <u>him</u> alive on <u>Jan. 23, 1958</u> Death occurred at <u>6:30 p.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W. Maxwell, D.O. Coroner</u>		22b. ADDRESS <u>307 W. Main, Savannah, Mo.</u>	22c. DATE SIGNED <u>3/24/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/24/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Turner Cemetery</u>
		23d. LOCATION (City, town, or county) <u>Wallace, Mo.</u>	(State)
24. FUNERAL DIRECTOR <u>Rupp Funeral Home, St. Joseph, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8-25-58</u>	26. REGISTRAR'S SIGNATURE <u>Kellian Sparks</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAY 21 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, ~~only~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *John E. Rupp*

Licensed Embalmer No. *3486*
P. O. Address *H. Joseph*

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.