

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-029549  
STATE FILE NUMBER

FILED SEP 2 1958

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 85

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Lawrence</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Mt. Vernon</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Higginsville</b> 65410 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. State Sanatorium</b>		Length of stay in lb <b>70 days</b>	d. STREET ADDRESS (If outside, give location) <b>111 E. 18th</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Amelia</b> Middle <b>Alfredia</b> Last <b>Rahm</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>20</b> Year <b>1958</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 9, 1895</b>	9. AGE (In years last birthday) <b>62</b>	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)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Philip Rahm</b>	13b. MOTHER'S MAIDEN NAME <b>Gora Ann Conklin</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>San. records, Mo. State San. Mt. Vernon Mo</b>	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) <b>Bronchogenic carcinoma, primary left lung with metastasis to liver, right lung and lymph nodes (cervical and axillary)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>approx. 8 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>1621A</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pulmonary tuberculosis, bilateral: Diabetes Mellitus</b>		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 a.m. p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION	COUNTY	STATE
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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 <b>6-11-58</b> to <b>8-20-58</b> and last saw her alive on <b>8-20-58</b> Death occurred at <b>6:00 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>P. A. Brasler M. D.</b>	22b. ADDRESS <b>Mt. Vernon, Mo.</b>	22c. DATE SIGNED <b>8-20-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-20-58</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <b>Higginsville, Mo.</b>
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24. FUNERAL DIRECTOR <b>Fossett Funeral Home, Mt. Vernon, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>8-21-58</b>	26. REGISTRAR'S SIGNATURE <b>Cecil H. Dicks</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc., must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be causally related.

JAN 2 1968

MS JAN 14 1968

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 W. G. Cantrell, Student Embalmer No. ....

working under my personal supervision

Student

W. G. Cantrell  
Signature of Student Embalmer

Signed

H. H. Lassett

Licensed Embalmer No.

2201

P. O. Address

Mt Vernon

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.