

Dr. Lemmon

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-039603  
STATE FILE NUMBER

FILED DEC 1 1958

Registration District No. 128 Primary Registration District No. 2600 Registrar's No. 1124

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>SPRINGFIELD</b> <sup>0396</sup>		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>ST. JOHN'S HOSP.</b>		Length of stay in 1b <b>56 YRS.</b>	d. STREET ADDRESS (If outside, give location) <b>315 S. DOLLISON</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EGBERT</b> Middle <b>E.</b> Last <b>SMITH</b>			4. DATE OF DEATH Month <b>NOV.</b> Day <b>21</b> Year <b>1958</b>		
5. SEX <b>MALE</b> <sup>0</sup>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 7 1872</b>	9. AGE (In years last birthday) <b>86</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>RETIRED SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INTERNATIONAL HARVESTER CO.</b>		11. BIRTHPLACE (City and state or country) <b>TENNESSEE</b> <sup>1</sup>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>JOHN B. SMITH</b>		13b. MOTHER'S M maiden NAME <b>ENIETE E. (UNKNOWN)</b>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, year or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>497-24-1770</b>	
17. INFORMANT <b>MRS. CHAS. STEPHENS RT # 3 SPFLD, MO.</b>		Address			
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>Carcinomatosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 wks.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>(primary unknown)</b>					
DUE TO (c)					
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.) <b>1992</b>		
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	
21. I attended the deceased from <b>11-11-58</b> to <b>11-21-58</b> and last saw him alive on <b>11-21-58</b> Death occurred at <b>5:10 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>G. Lemmon, M.D.</b> (Degree or title)			22b. ADDRESS <b>Springfield, Mo.</b>		22c. DATE SIGNED <b>11-25-58</b>
23a. BURIAL, CREMATION, REBURYAL (Specify) <b>BURIAL</b>		23b. DATE <b>11/24/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Unknown</b>		23d. LOCATION (City, town, or county) (State) <b>LOCKWOOD, MO.</b>
24. FUNERAL DIRECTOR <b>H.H. LOHMEYER</b>		ADDRESS <b>SPRINGFIELD, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>11-26-58</b>	26. REGISTRY'S SIGNATURE <b>Effie G. Melton</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *Gene C. Hunter* .....

Licensed Embalmer No. *4739* .....

P. O. Address *Spd, Mo.* .....

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.