

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000682  
STATE FILE NUMBER

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 25

**FILED JAN 27 1959**

1. PLACE OF DEATH a. COUNTY <u>Cole</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cole</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City</u>		c. CITY (If outside, give location) OR TOWN <u>Jefferson City</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Charles E. Still Hospital</u>		d. STREET (If outside, give location) ADDRESS <u>624 W Main</u>	
3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>SHANE</u> Last <u>LAIRMORE</u>		4. DATE OF DEATH Month <u>January</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 21, 1959</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13a. FATHER'S NAME <u>William Lairmore</u>		13b. MOTHER'S MAIDEN NAME <u>Carol Lee Keene</u>	14. NAME OF HUSBAND OR WIFE <u>None</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 Address <u>Mrs. Carol Larimore J C 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>Medullary paralysis</u> DUE TO (b) <u>Prematurity.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>24 h</u>
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 _____ 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 <u>Jan. 21, 1959</u> to <u>Jan. 22, 1959</u> and saw her alive on _____ Death occurred at <u>9:15</u> p. _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J E Duffer</u> (Deputy or title)		22b. ADDRESS <u>420 E. High St. - JEFFERSON City, Mo.</u>	22c. DATE SIGNED <u>1-23-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/24/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson City, Mo.</u>
24. FUNERAL DIRECTOR <u>Stephen A. Smith</u> ADDRESS <u>J C Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>26 Jan 1959</u>	26. REGISTRAR'S SIGNATURE <u>R. P. Dorrie, Mo. - JR</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 ..... *Sylvester A. Smith*

Licensed Embalmer No. *4321*

P. O. Address *Jefferson City*

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.