Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004342
STATE FILE NUMBER

FILED MAR 2 1959 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 69

1. PLACE OF DEATH a. COUNTY Adair	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Sullivan
b. CITY OR TOWN Kirksville — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN Green Castle — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Laughlin Hospital — Length of stay in hospital 1 day	d. STREET ADDRESS (If outside, give location) No street address — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print)	First: Steven	Middle: Allen	Last: Lewis	4. DATE OF DEATH: Month Feb. Day 19, Year 1959
5. SEX: Male	6. COLOR OR RACE: White	7. MARITAL STATUS: MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH: 10-11-1954	9. AGE (In years last birthday): 4 — 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): None	10b. KIND OF BUSINESS OR INDUSTRY: None	11. BIRTHPLACE (City and state or country): Kirksville, Mo.	12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME: Fred E. Lewis	13b. MOTHER'S MAIDEN NAME: Grace Cooley	14. NAME OF HUSBAND OR WIFE: Never married		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ___	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Fred E. Lewis, Address: Green Castle, Mo.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fibrosarcoma Rt t. Bia with — INTERVAL BETWEEN ONSET AND DEATH: Aug 1957
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Metastasis to Both Lungs
DUE TO (c) ___
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 1967
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 FEB 18-1959, to FEB 14-1959 and last saw ~~her~~ him alive on FEB 19-1959
Death occurred at 1:26 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Earl Laughlin Jr (Degree or title) Dr. — 22b. ADDRESS Kirksville, Mo — 22c. DATE SIGNED 2-25-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE: 2-22-1959 — 23c. NAME OF CEMETERY OR CREMATORY: Lipp Cemetery — 23d. LOCATION (City, town, or county) (State): Putnam County, Mo.

24. FUNERAL DIRECTOR: Glenn E. Kent & Son — ADDRESS: Green City, Mo. — 25. DATE RECD. BY LOCAL REG.: 2-27-1959 — 26. REGISTRAR'S SIGNATURE: Doris W. Ratliff

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

EARL LAUGHLIN, JR., D.O.

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 Karl R. Kent

Licensed Embalmer No. 4689

P. O. Address Green 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.