

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019426

STATE FILE NUMBER

FILED JUN 4 1959

Registration District No.

Primary Registration District No.

Registration No. 4849

300  
-57

73  
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 5826 Maple	
Length of stay in 1b 21 Years		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Lorenzo H. Mass			4. DATE OF DEATH Month Day Year 5 17 59		
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-17-1904	9. AGE (In years last birthday) 54	IF UNDER 1 YEAR Months Days	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) Labor	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) THEBEE ARKANSAS	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Emp Mass.	13b. MOTHER'S MAIDEN NAME ISIDEE HARRISON.	14. NAME OF HUSBAND OR WIFE MATTIE MASS.
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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)	16. SOCIAL SECURITY NO. 495-14-6202	17. INFORMANT Address MATTIE MASS. 5826 MAPLE.
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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) <i>Carcinomatous</i>		INTERVAL BETWEEN ONSET AND DEATH  undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Bronchogenic Carcinoma</i>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>162.1</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) ITEM 13b CORRECTED BY AFFIDAVIT OF <i>Funeral Director</i>
20c. TIME OF INJURY Hour Month, Day, Year p.m.	

20d. INJURY OCCURRED WHILE AT WORK <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 <u>4-9-59</u> to <u>5-17-59</u> and last saw <sup>him</sup> alive on <u>5-17-59</u> Death occurred at <u>7:50</u> <u>P</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <i>S. A. Truse</i> , M.D.	22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 5-18-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-23-1959	23c. NAME OF CEMETERY OR CREMATORY Washington Park	23d. LOCATION (City, town, or county) (State) County MO.
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24. FUNERAL DIRECTOR ADDRESS JOHN W. BROOM . 2616 N. Garrison	25. DATE RECD. BY LOCAL REG. MAY 19 59	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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(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

MEDICAL CERTIFICATION

*mib*

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

*Leroy R. Fannister*

Licensed Embalmer No. *4523*

P. O. Address *4251 Washing*

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.