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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-019995
STATE FILE NUMBER

FILED MAY 25 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1397

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Creve Coeur — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Creve Coeur Mill Road — Length of stay in Hospital 8 years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Creve Coeur 4000 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) Creve Coeur Mill Rd. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: BENJAMIN Middle: LAWRENCE Last: LOVETT

4. DATE OF DEATH Month, Day, Year: MAY 17, 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Mar. 29, 1899
9. AGE (In years last birthday): 60 — 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): Chef
10b. KIND OF BUSINESS OR INDUSTRY: Crystal Cafe
11. BIRTHPLACE (City and state or country): Canada
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Katherine Lovett

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.: 325-14-3634
17. INFORMANT: Katherine Lovett, Address: Route #2, Box #532

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) CARCINOMA OF RIGHT LUNG WITH WIDESPREAD METASTASES — INTERVAL BETWEEN ONSET AND DEATH: INDETERMINED
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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): 163x
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

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 APRIL 1, 1959 to APRIL 24, 1959 and last saw her/him alive on APRIL 24, 1959
Death occurred at 8:- a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE C. Vermillion, M.D. (Degree or title) M. D.
22b. ADDRESS BARNES HOSPITAL
22c. DATE SIGNED 5/18/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 5-20-1959
23c. NAME OF CEMETERY OR CREMATORY: Fee Fee Cemetery
23d. LOCATION (City, town, or county) (State): Bridgeton, Missouri

24. FUNERAL DIRECTOR: Baumann Bros. Inc. Overland, Mo. ADDRESS 2504 Woodson Rd.
25. DATE RECD. BY LOCAL REG.: 5-19-59
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 David C. Gibson

Licensed Embalmer No. 3454

P. O. Address Emeryville

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.