Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-021141
STATE FILE NUMBER

FILED JUN 29 1959 Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 73

1. PLACE OF DEATH
a. COUNTY Howell
b. CITY OR TOWN West Plains — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION West Plains Memorial Hosp. — Length of stay in 1b 24 hrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Howell
c. CITY OR TOWN Pomona — Inside Limits Yes ☐ No ☑
d. STREET ADDRESS Rt 2 (If outside, give location) — Reside on Farm Yes ☑ No ☐

3. NAME OF DECEASED (Type or print) First Scott Middle Manuel Last Falwell
4. DATE OF DEATH Month 6 Day 8 Year 59
5. SEX M
6. COLOR OR RACE Wht
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12-2-1905
9. AGE (In years last birthday) 53 — IF UNDER 1 YEAR Months 6 Days 6 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Howell Co. Mo.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Ralph Falwell
13b. MOTHER'S MAIDEN NAME Ellen Burk
14. NAME OF HUSBAND OR WIFE Bessie Falwell
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. Yes
17. INFORMANT Mrs S. M. Falwell Address Pomona Rt 2

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 lung — INTERVAL BETWEEN ONSET AND DEATH 10 months
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 ☐ 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 5/30/55 to 6/8/59 and last saw her/him alive on June 8
Death occurred at 9:15 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE M. L. Fowler (Degree or title) MD
22b. ADDRESS 914 W. Broadway
22c. DATE SIGNED 6/15/59

23a. BURIAL, CREMATION, REMOVAL (Specify) B
23b. DATE 6-11-59
23c. NAME OF CEMETERY OR CREMATORY New Liberty Cem.
23d. LOCATION (City, town, or county) West Plains (State) Mo.

24. FUNERAL DIRECTOR Robertson
ADDRESS West Plains Mo.
25. DATE RECD. BY LOCAL REG. 6-23-59.
26. REGISTRAR'S SIGNATURE Beatrice Cook

(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.

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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 .....

Licensed Embalmer No. 3432

P. O. Address .....

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.