

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029672

FILED VS SEP 2 1959 383

Registration District No. _____ Primary Registration District No. 5655 Registrar's No. 100

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt. Vernon</u>		Length of stay in 1b <u>911 days</u>		c. CITY OR TOWN <u>Joplin</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. State Sanatorium</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>710 W. 26th St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charley Ervin Lemmons</u>				4. DATE OF DEATH Month Day Year <u>August 26, 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-4-90</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>JOPLIN FOUNDRY</u>		11. BIRTHPLACE (City and state or country) <u>Kansas (GALENA)</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Andrew Jackson Lemmons</u>			13b. MOTHER'S MAIDEN NAME <u>Annie Love</u>		14. NAME OF HUSBAND OR WIFE <u>MYRTLE MAY LEMMONS,</u> <u>DEC'D 9-5-44</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>500-09-4430</u>		17. INFORMANT <u>San.records, Mo.State San.,Mt.Vernon, 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>Pulmonary tuberculosis Far Advanced, Active</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
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)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year							
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
21. I attended the deceased from <u>2-26-57</u> , to <u>8-26-59</u> and last saw him <u>xx</u> alive on <u>8-26-59</u> Death occurred at <u>6:30 a.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Samuel T. Wilson M.D.</u> (Degree or title)				22b. ADDRESS <u>Mt. Vernon, Mo.</u>		22c. DATE SIGNED <u>8-26-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-26-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FOREST PARK CEMETERY</u>		23d. LOCATION (City, town, or county) <u>Joplin, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>STEVE PARKER MORTUARY, JOPLIN, MO.</u>			ADDRESS	25. DATE RECD. BY LOCAL REG. <u>8-28-59</u>	26. REGISTRAR'S SIGNATURE <u>Cecil Kendrick</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

001

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed F. M. Jones

Licensed Embalmer No. 2319

P. O. Address Joplin

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.