

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029870

FILED VS AUG 27 1959

Registration District No. 240 Primary Registration District No. 5827 Registrar's No. 20

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lewis Twsp</u>		Length of stay in 1b <u>8 yrs</u>		c. CITY OR TOWN <u>Lilbourn</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4m. N of Lilbourn</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4m. n. of Lilbourn</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Mortie</u> Middle <u>Lee</u> Last <u>Lawrence</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>15</u> Year <u>1959</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>May 19, 02 57</u>		9. AGE (last birthday) <u>57</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>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Appleton, Ark</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>						
13a. FATHER'S NAME <u>Unknown</u>				13b. MOTHER'S MAIDEN NAME <u>Unknown</u>				14. NAME OF HUSBAND OR WIFE <u>Opal Lawrence</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>422-05-1887</u>		17. INFORMANT <u>Carrie L. Moore-Gideon, Mo.</u> Address _____							
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>Carcinoma of lung</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) 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										INTERVAL BETWEEN ONSET AND DEATH <u>18 Mo.</u>			
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.) _____									
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>June 1958</u> , to <u>14 Aug 59</u> and last saw <sup>her</sup> him alive on <u>14 Aug 59</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Charles Wheeler, MD</u> (Degree or title)				22b. ADDRESS <u>New Madrid, Mo</u>				22c. DATE SIGNED <u>18 Aug 59</u> (State)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug 18, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Appleton, cemetery</u>				23d. LOCATION (City, town, or county) <u>Appleton Ark</u>					
24. FUNERAL DIRECTOR <u>Russell-Peggott, Ark</u> ADDRESS _____				25. DATE RECD. BY LOCAL REG. <u>8-19-1959</u>		26. REGISTRAR'S SIGNATURE <u>H. L. Gonder, Deputy</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

2931 1 1977

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

~~on by~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Floyd Russell*

Licensed Embalmer No. 509

P. O. Address Jiggott

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.