RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-033471

STATE FILE NUMBER

FILED VS OCT 6 1959

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 370

DED

1. PLACE OF DEATH a. COUNTY St. Francois

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Francois

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bonne Terre — Length of stay in 1b 25 yrs.

c. CITY OR TOWN Bonne Terre, Mo. — Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bonne Terre Hosp. — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 420 N. Division — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Middle Last: * LAWRENCE WEBB LEMON *

4. DATE OF DEATH Month Day Year: Sept. 28, 1959

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 11-17-1885

9. AGE (last birthday): 73 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (City and state or country): Clinton, Ill.

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Richard A. Lemon

13b. MOTHER'S MAIDEN NAME: Opha Kyle

14. NAME OF HUSBAND OR WIFE: Lillian Kraft

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 494-03-9754

17. INFORMANT Address: Mrs. L.W. Lemon Bonne Terre, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchiogenic Carcinoma

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) left lung with liver —

DUE TO (c) Metastases

INTERVAL BETWEEN ONSET AND DEATH: 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Purulent bilateral bronchopneumonia

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 Aug. 24, 1959, to Sept. 28, 1959 and last saw him alive on Sept. 28, 1959

Death occurred at 2:30 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Marvin T. Haw Jr. M.D.

22b. ADDRESS: Bonne Terre, Mo.

22c. DATE SIGNED: 9/29/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Oct 1 1959

23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery

23d. LOCATION (City, town, or county) (State): Clinton, Illinois

24. FUNERAL DIRECTOR ADDRESS: C.Z. BOYER & SON INC. Bonne Terre

25. DATE RECD. BY LOCAL REG.: Sept. 29, 1959

26. REGISTRAR'S SIGNATURE: Esther Rudloff

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed B. T. Boyer

Signature of Student Embalmer

B. T. BOYER

Licensed Embalmer No. 3 6 6

P. O. Address Desloge, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to c 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.