

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034009

FILED OCT 5 1959

2 8643

STATE FILE NUMBER

ENDED

Registration District No. Primary Registration District No. Registrar's No.

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>WASHINGTON</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis, Missouri</b>                 |  | Length of stay in 1b  | c. CITY OR TOWN <b>Mineral Point</b>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Bethesda General Hospital</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>Reside on Farm</b><br>Yes <input type="checkbox"/> No <input type="checkbox"/> |

|  |                                  |   |   |   |   |  |
|--|----------------------------------|---|---|---|---|--|
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>John</b> Middle <b>La Chance</b> Last <b>La Chance</b>            |                                  |   | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>20</b> Year <b>1959</b> |   |   |  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/29/04</b>                                    | 9. AGE (last birthday)<br><b>55</b>                         | IF UNDER 1 YEAR<br>Months <b>  </b> Days <b>  </b> Hours <b>  </b> Min. <b>  </b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MINER</b>          |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OLD MINES, MO.</b>  |   | 11. BIRTHPLACE (City and state or country)<br><b>U.S.A.</b> |   |  |
| 13a. FATHER'S NAME<br><b>NOT KNOWN</b>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>CATHERINE POLITTE</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>EATHERINE LA CHANCE</b>   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, or unknown) (If yes, give war or dates of service)<br><b>NO</b> |                                  | 16. SOCIAL SECURITY NO.<br><b>48-18-000-SP</b>  |   | 17. INFORMANT<br><b>DR. PLAINS ILL.</b>                     |   |  |

|   |   |   |
|---|---|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <b>Carcinoma of Gall bladder</b> |   |
|   | DUE TO (c) <b>  </b>                        |   |

|   |  |  |  |
|---|--|--|--|
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
|---|--|--|--|

|  |   |  |              |
|--|---|--|--------------|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour <b>  </b> a.m. <b>  </b> p.m. <b>  </b>                                    | Month, Day, Year <b>  </b>  |  |              |
| 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 **8-26-1959** to **9-20-1959** and last saw her/him alive on **9-19-1959**.  
Death occurred at **8am 9/20 1959** on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                             |   |   |
|--|-----------------------------|---|---|
| 22a. SIGNATURE<br><b>John W Stewart M.D.</b>               | (Degree or title)           | 22b. ADDRESS<br><b>466 Maryland St. St. Louis 8 MO</b>    | 22c. DATE SIGNED<br><b>9/20/59</b>                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b> | 23b. DATE<br><b>9-22-59</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SUNSET HILLS</b> | 23d. LOCATION (City, town, or county) (State)<br><b>POTOSI, MO.</b> |

|   |                               |  |  |
|---|-------------------------------|--|--|
| 24. FUNERAL DIRECTOR<br><b>OMAN JENNINS</b> | ADDRESS<br><b>POTOSI, MO.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>9-20-1959</b> | 26. REGISTRAR'S SIGNATURE<br><b>Paul Smith, M.D.</b> |
|---|-------------------------------|--|--|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 14 1959

OCT 5 1959

**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 Murphy L. Sparks

Licensed Embalmer No. 4336

P. O. Address Flat River Mo

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.