

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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FILED VS FEB 8 1960

Registration District No. 002 Primary Registration District No. 5013 Registrar's No. 13

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ANDREW</u> b. CITY (If outside corporate limits, give TOWNSHIP) OR TOWN <u>JACKSON TOWNSHIP</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ANDREW</u> c. CITY OR TOWN <u>RFD # 1 SAVANNAH</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>5 mile northwest</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>OTIS SHERMAN LANCE</u>			4. DATE OF DEATH Month Day Year <u>January 27, 1960</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>2-15-00</u>	9. AGE (last birthday) <u>59</u> 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) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTHPLACE (City and state or country) <u>Andrew County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		
13a. FATHER'S NAME <u>DAVID LANCE</u>		13b. MOTHER'S MAIDEN NAME <u>KATTIE WARDLOW</u>		14. NAME OF HUSBAND OR WIFE <u>MABEL LANCE</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>489-38-3128</u>		17. INFORMANT Address <u>Mrs. Mabel Lance, RFD # 1 Savannah</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>Cardiac arrest</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral atrophy</u> 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					INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>6 months</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>11/10/47</u> to <u>1/27/60</u> and last saw ^{her} him alive on <u>1/24/60</u> Death occurred at <u>5:15 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Wesley Maxwell, M.D.</u>			22b. ADDRESS <u>307 W. Main, Savannah, Mo.</u>		22c. DATE SIGNED <u>2/3/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>1-29-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Savannah Cemetery</u>			
23d. LOCATION (City, town, or county) (State) <u>Savannah, Missouri</u>		24. FUNERAL DIRECTOR ADDRESS <u>BREIT & HAWKINS SAVANNAH</u>		25. DATE RECD. BY LOCAL REG. <u>2-4-60</u>			
26. REGISTRAR'S SIGNATURE <u>Lillian Sparks</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 James B. Hewke

Licensed Embalmer No. 4536

P. O. Address Sevanna

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