

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000143

FILED VS FEB 2 1960

Registration District No. 27 Primary Registration District No. 5100 Registrar's No. 10

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Bates</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Bates</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Merwin W. Boone</u>		Length of stay in 1b <u>5 months</u>		c. CITY OR TOWN <u>Merwin</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>none</u>				d. STREET ADDRESS (If outside, give location) <u>none</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Paulette</u> Last <u>Lee</u>				4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2-27-59</u>	9. AGE (last birthday) <u>10</u> Months <u>16</u> Days	IF UNDER 24 HR Hours <u>16</u> Min.	IF UNDER 24 HR Hours <u>16</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Drexel, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Russell Bland Lee</u>			13b. MOTHER'S MAIDEN NAME <u>Mable Sherrill</u>			14. NAME OF HUSBAND OR WIFE <u>none</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>none</u>		17. INFORMANT <u>Russell B. Lee, Merwin, Missouri</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>CARDIOVASCULAR Collapse</u>						INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>BILATERAL LOBAR PNEUMONIA</u>						8-10 hrs	
DUE TO (c) <u>CONGENITAL CARDIAC INSUFFICIENCY</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>PREMATURE BIRTH</u>						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 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 <u>10:30</u> a.m. <u>am</u> Month, Day, Year <u>2/27/59</u>		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 <u>Drexel, Mo.</u>	
21. I attended the deceased from <u>2/27/59</u> to <u>1/13/60</u> and last saw ^{her} <u>1/13/60</u> Death occurred at <u>10:30 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Ed Marsh D.O.</u>				22b. ADDRESS <u>Drexel, Mo.</u>		22c. DATE SIGNED <u>1-15-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-15-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sharon Cemetery</u>		23d. LOCATION (City, town, or county) <u>Drexel, Mo.</u>		23e. STATE <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>Archer & Mangold, Amsterdam, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>Jan. 15-1960</u>		26. REGISTRAR'S SIGNATURE <u>Russell B. Lee</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 Robert L. Mangano

Licensed Embalmer No. 497

P. O. Address La Vega

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.