

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008501

FILED VS FEB 18 1960

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 1471** STATE FILE NUMBER

DED

|   |  |   |  |  |  |  |   |   |  |
|---|--|---|--|--|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSISSIPPI</b> b. COUNTY <b>Monroe</b> |  |  |   |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>ST LOUIS MISSOURI</b>   |  | Length of stay in lb<br><b>39 DAYS</b>  |  | c. CITY OR TOWN <b>AMORY</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><b>FRISCO EMPLOYEES' HOSPITAL</b>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  | d. STREET ADDRESS (If outside, give location)<br><b>603 Bankhead Street.,</b>    |  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Jacob</b> Middle <b>Lantrip</b><br><b>JACOB LANTRIP</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>FEBRUARY</b> Day <b>7<sup>th</sup></b> Year <b>1960</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>2/18/1900</b>   | 9. AGE (last birthday)<br><b>59</b>  | IF UNDER 1 YEAR<br>Months _____ Days _____   | IF UNDER 24 HR<br>Hours _____ Min. _____  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>YARDMASTER RAILROAD</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Frisco R. R.</b>                             |  | 11. BIRTHPLACE (City and state or country)<br><b>Walker County, Alabama</b>      |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b> |   |  |
| 13a. FATHER'S NAME<br><b>JAMES Lantrip</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Janie Lou Payne</b>                                  |  |  | 14. NAME OF HUSBAND OR WIFE<br><b>DOROTHY M.</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, go, or unknown) (If yes, give war or dates of service)<br><b>Yes W.W. I</b>  |  |   | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |  | 17. INFORMANT<br><b>Dorothy M. Lantrip, Amory, Mississippi.</b><br>Address _____ |  |   |   |  |
| 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>CHRONIC MYELOGENOUS LEUKEMIA</b>   |  |   |  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>38 DAYS</b>                                    |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |  |   |  |  |  |  |   | <b>2041</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 checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m.   |  | Month, Day, Year _____  |  |  |  |  |   |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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 <b>DECEMBER 31 1959</b> to <b>FEBRUARY 7 1960</b> and last saw him alive on <b>FEB 7 1960</b><br>Death occurred at <b>8 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |  |  |  |   |   |  |
| 22a. SIGNATURE<br><i>[Signature]</i> (Degree or title)<br><b>M.D.</b>   |  |   |  | 22b. ADDRESS<br><b>FRISCO HOSPITAL<br/>ST LOUIS MISSOURI</b>   |  |  |   | 22c. DATE SIGNED<br><b>4/7/60</b>   |  |
| 23b. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |  | 23b. DATE<br><b>2/8/60</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Local</b>                                   |  |  | 23d. LOCATION (City, town, or county)<br><b>Amory, Mississippi.</b>  |   | 23d. LOCATION (State)<br><b>Mississippi.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Albert H. Hoppe Inc., 4700 Washington Blvd.,</b>   |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>FEB 8 1960</b>  |  | 26. REGISTRAR'S SIGNATURE<br><i>[Signature]</i><br><b>M.D.</b>   |   |   |  |

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 Elton H. Remelick

Licensed Embalmer No. 4273

P. O. Address St. Louis

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.

APR 7 1960

MAR 25 1960

MAR 1 1960

0960