

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-024262

FILED VS JUN 29 1960

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 249 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST. FRANCOIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. FRANCOIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>DOERUN</u>		c. CITY OR TOWN <u>DOERUN</u>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>A</u> Last <u>LEE</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>16</u> Year <u>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>FEB. 14, 1890</u>	9. AGE (last birthday) <u>70</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>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>ST. FRANCOIS, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>ANDREW LEE</u>		13b. MOTHER'S MAIDEN NAME <u>CAROLINE MITCHELL</u>		14. NAME OF HUSBAND OR WIFE <u>MILDRED LEE</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.		17. INFORMANT <u>Mildred Lee Doerun, Mo.</u> Address _____		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cachexia</u>		<u>1 wk</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Pulmonary Tuberculosis</u>	<u>3 mo</u>
	DUE TO (c) <u>Carcinoma of the lung</u>	<u>3 mo</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Carcinoma of the lung</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	
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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 <u>DOERUN, MO.</u>	COUNTY _____ STATE _____
21. I attended the deceased from <u>6:30</u> <u>6/13/60</u> to <u>6:30</u> <u>6/13/60</u> and last saw him alive on <u>6/13/60</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>C. W. Sebastian MD</u>		22b. ADDRESS <u>Farmington Mo</u>		22c. DATE SIGNED <u>6/21/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JUNE 19, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MASONIC CEM.</u>	23d. LOCATION (City, town, or county) <u>DOERUN, MO.</u>	

24. FUNERAL DIRECTOR <u>Raymond Colwell & Sons, Farmington, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>June 21, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</u>
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

0961 I 700

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 R. Caldwell

Licensed Embalmer No. 2531

P. O. Address Flat R

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.