

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-027475

FILED VS AUG 1 1960

174

Primary Registration District No. 3035

Registrar's No. 67

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>LAFAYETTE</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u> Length of stay in 1b <u>42 yr.</u> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>744 Highland</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LAFAYETTE</u> c. CITY OR TOWN <u>Lexington</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>744 Highland</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY M. CHRIST</u>			4. DATE OF DEATH Month Day Year <u>July 17 1960</u>				
5. SEX <u>Female</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 2-1901</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>15</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife - Retail Grocery, Own apartment</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barouk LeBANON</u>		11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Fares Nasseef</u>			13b. MOTHER'S MAIDEN NAME <u>NAKHE SALEM</u>		14. NAME OF HUSBAND OR WIFE <u>James M. Christ</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 Address <u>James M. Christ, Lexington</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>Metastatic Carcinoma</u> DUE TO (b) <u>Carcinoma of breast</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>1955</u>	
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		
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>July 12, 60</u> to <u>July 17 '60</u> and last saw her <u>July 17, 60</u> alive on Death occurred at <u>7:15 pm</u> on <u>the date stated above, and to the best of my knowledge, from the causes stated.</u>							
22a. SIGNATURE <u>Joe W. Ward MD</u> (Degree or title)				22b. ADDRESS <u>Lexington Mo</u>		22c. DATE SIGNED <u>7-18-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>7-19-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Lexington Mo</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Wagner-WALKER-Lexington Mo. 7-19-60</u>			25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE <u>Maura S. Eastbrook</u>		

DED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 4 1960

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 Harold L. Wain

Licensed Embalmer No. 4588

P. O. Address Lexington

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.