

MORTUARY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-029376

FILED VS. AUG 1 1960
 ENDED

Primary Registration District No. 352 Registrar's No. 57 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>TANEY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>TANEY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>HOLLISTER</u>		Length of stay in 1b <u>LIFE</u>	c. CITY OR TOWN <u>HOLLISTER</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOME (So. of Hollister)</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR F. LEWALLEN</u>			4. DATE OF DEATH Month Day Year <u>7-9-60</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>9/6/1900</u>
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	9. AGE (last birthday) <u>59</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11. BIRTHPLACE (City and state or country) <u>TANEY County, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JESSIE LEWALLEN</u>		13b. MOTHER'S MAIDEN NAME <u>ELLEN HUNTER</u>	14. NAME OF HUSBAND OR WIFE <u>LOISIE LEWALLEN</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>495-40-6529</u>	17. INFORMANT Address <u>LOISIE LEWALLEN - Hollister, Mo.</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>Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerosis - Generalized</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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 Month, Day, Year a.m. p.m.			
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>DOA.</u> to <u>7/9/60</u> and last saw ^{him} alive on <u>7/8/60</u> Death occurred at <u>about 10</u> <u>2</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Roy Gillispie M.D.</u> (Degree or title)		22b. ADDRESS <u>Brunson Mo</u>	22c. DATE SIGNED <u>7/29/60</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BYRIAL</u>	23b. DATE <u>7/2/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OMAHA</u>	23d. LOCATION (City, town, or county) (State) <u>OMAHA ARK.</u>
24. FUNERAL DIRECTOR <u>HOLT MEMORIAL CHAPEL - HARRISON, ARK</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>7/29/60</u>	26. REGISTRAR'S SIGNATURE <u>Robert Campbell</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 _____

Licensed Embalmer No. 1061

P. O. Address Harrison

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.