

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-032509

FILED VS SEP 2 1960 318

1003

8381

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

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

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| 3. NAME OF DECEASED (Type or print) First CLYDE Middle F. Last LASATER | | | 4. DATE OF DEATH Month AUGUST Day 24 Year 1960 | | | |
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| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Sept 7, 1882 | 9. AGE (last birthday) 77 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | 10b. KIND OF BUSINESS OR INDUSTRY Retired. | 11. BIRTHPLACE (City and state or country) Mc Clains Borough Ill. U.S.A. | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME Ed. Lasater | 13b. MOTHER'S MAIDEN NAME Annie Hollord | 14. NAME OF HUSBAND OR WIFE Mary Lasater |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Address Mrs. Leo Wolls Corning Ark. |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HODGKIN'S DISEASE | | INTERVAL BETWEEN ONSET AND DEATH 5 YRS. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | |
| | DUE TO (c) | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) BRONCHOPNEUMONIA | 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.) |
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| 20c. TIME OF INJURY Hour 1:20 am. A.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 CORNING ARK. | COUNTY | STATE |
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| 21. I attended the deceased from APRIL 6, 1960 to AUG. 24, 1960 and last saw her/him alive on AUG. 24, 1960 | |
| Death occurred at 1:20 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | |

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| 22a. SIGNATURE <i>E. J. McMillan, M.D.</i> | 22b. ADDRESS BARNES HOSPITAL | 22c. DATE SIGNED 8/24/60 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 8-28-60 | 23c. NAME OF CEMETERY OR CREMATORY CORNING CEMETERY | 23d. LOCATION (City, town, or county) CORNING ARK. |
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| 24. FUNERAL DIRECTOR ADDRESS Russell and Emert Cotnam, Ark. | 25. DATE RECD. BY LOCAL REG. AUG 26 1960 | 26. REGISTRAR'S SIGNATURE <i>Leon Smith, M.D.</i> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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. 253

P. O. Address Flat River

STATEMENT BY LICENSED EMBALMER

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.

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