

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 26 1960

-60-033905

INDEXED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 983 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>	Length of stay in 1b	c. CITY OR TOWN <u>Sathrop</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>Missouri Meth. Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R.J.D.</u>

3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Carlisle</u> Last <u>Lee</u>			4. DATE OF DEATH Month <u>SEPT.</u> Day <u>16</u> Year <u>1960</u>	
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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>5/8/1887</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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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	11. BIRTHPLACE (City and state or country) <u>Campbellsburg, Ky.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Levi H. Lee</u>	13b. MOTHER'S MAIDEN NAME <u>Mariah Jackson</u>	14. NAME OF HUSBAND OR WIFE <u>Helen Lee</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>498-46-6628</u>	17. INFORMANT <u>Mrs. Helen Lee</u>	Address <u>Sathrop, Mo.</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u>		<u>4 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary Thrombosis</u>	<u>2 weeks</u>
	DUE TO (c) <u>Arteriosclerotic heart disease</u>	<u>5+ years</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
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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 _____ 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>Plattsburg, Mo.</u>	COUNTY	STATE
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21. I attended the deceased from <u>Sept. 2, 1960</u> to <u>Sept. 16, 1960</u> and last saw ^{her} him alive on <u>Sept. 16, 1960</u> Death occurred at <u>4 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>P.T. Luchenbill, MD</u> (Degree or title)	22b. ADDRESS <u>Plattsburg, Mo.</u>	22c. DATE SIGNED <u>9-17-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/18/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sathrop Cemetery</u>	23d. LOCATION (City, town, or county) <u>Sathrop, Missouri</u> (State)
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24. FUNERAL DIRECTOR <u>Syon Funeral Home Inc. Plattsburg, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Sept. 18, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodill</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF P.T. Luchenbill, M.D. CERTIFICATION

0961 2 2 AON

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 Philip E. Cox

Licensed Embalmer No. 4993

P. O. Address Lawrenceburg, Mo.

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.