

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60=035868

FILED VS. SEP 21 1960 3/6

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 366

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY ST FRANCOIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY ST FRANCOIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN BONNE TERRE		Length of stay in lb 2 days.	c. CITY OR TOWN FARMINGTON Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BONNE TERRE HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 405 W 6th. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last LIONEL GAY TETLEY	4. DATE OF DEATH Month Day Year SEPT. 14 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 2/17/94	9. AGE (last birthday) 66	IF UNDER 1 YEAR Months Days	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 Asst. State Service Officer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) FARMINGTON MO.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME SAMUEL J TETLEY	13b. MOTHER'S MAIDEN NAME BETTY H GHOLSON	14. NAME OF HUSBAND OR WIFE
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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) YES WORLD WAR 1	16. SOCIAL SECURITY NO. 498-10-6086	17. INFORMANT ROBERTA TETLEY FARMINGTON MO.	Address 612 W COLUMBIA
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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 2 1/2 mos
IMMEDIATE CAUSE (a) Carcinoma of lung with generalized metastases		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

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 checked="" 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
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21. I attended the deceased from 7-12-60 to Sept 14, 1960 and last saw him alive on 9-13-60 Death occurred at 9:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) George L. Watters M.D.	22b. ADDRESS Farmington Mo.	22c. DATE SIGNED 9-15-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9/16/60	23c. NAME OF CEMETERY OR CREMATORY PARKVIEW	23d. LOCATION (City, town, or county) (State) FARMINGTON MISSOURI
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24. FUNERAL DIRECTOR C.H. COZEAN FARMINGTON MO.	25. DATE RECD. BY LOCAL REG. Sept. 16, 1960	26. REGISTRAR'S SIGNATURE Cather Rudloff
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 21 1960

NOV 20 1960

NOV 2 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 _____

W. Cozad
4

Licensed Embalmer No. _____

P. O. Address. *Farrington*

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.