

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

ED VS JAN 9 1961

-60-045209  
STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1360

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Nodaway</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Joseph</u>		Length of stay in lb <u>4</u> <u>das</u>		c. CITY OR TOWN <u>Graham</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>Mo. Methodist</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RUSSELL</u> Middle <u>M</u> Last <u>LEMAR</u>				4. DATE OF DEATH Month <u>12</u> , Day <u>26</u> , Year <u>1960</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>cau.</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>11.6.1900</u>	9. AGE (last birthday) <u>60</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
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 <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Mondoman, Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>James Lemar</u>			13b. MOTHER'S MAIDEN NAME <u>Cora Mears</u>			14. NAME OF HUSBAND OR WIFE <u>Frankie Lemar</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>491-42-1477</u>		17. INFORMANT Address <u>Mrs Frankie Lemar, Graham Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN.</u>	
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		
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>12-23-60</u> to <u>12-26-60</u> and last saw <sup>her</sup> him alive on <u>12-26-60</u> Death occurred at <u>6</u> <u>P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>J.A. Forgrave</u> (Degree or title)				22b. ADDRESS <u>420 N 8<sup>2</sup> St St Joseph Mo</u>			22c. DATE SIGNED <u>12-29-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-28-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Graham Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Graham, Missouri</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Atchison Funeral Home</u> <u>Maryville, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Jan 3, 1961</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 10 1961

**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

*George M. Atchison*

Licensed Embalmer No. 2279

P. O. Address

*Weymouth*

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.