

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004735

STATE FILE NUMBER

AMENDED

Registration District No. 47 Primary Registration District No. 5169 Registrar's No. 41

FILED VS FEB 21 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Callaway</b>		a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Nine Mile Prairie Twp;</b>		c. CITY OR TOWN <b>Sappington</b>	
Length of stay in 1b -----		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>U.S. Route 40</b>		d. STREET ADDRESS (If outside, give location) <b>9525 Donalds Court</b>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First Middle Last <b>Granville Cloves Lemmons</b>			Month Day Year <b>February 17 1961</b>			

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/10/1919</b>	9. AGE (last birthday) <b>41</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
-----------------------	----------------------------------	---	--------------------------------------	-------------------------------------	---	------------------------------

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Kitchen manager</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Restraunt</b>	11. BIRTHPLACE (City and state or country) <b>Arkansas</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
--	---	---	---

13a. FATHER'S NAME <b>Oscar Lemmons</b>	13b. MOTHER'S MAIDEN NAME <b>Ibbie Sexton</b>	14. NAME OF HUSBAND OR WIFE <b>La Verne Lemmons</b>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes WW 2</b>	16. SOCIAL SECURITY NO. <b>2</b>	17. INFORMANT <b>9525 Donalds Court Wife- Sappington, Missouri</b>
---	-------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Head and Internal injuries, probably</b>		<b>Instant</b>
DUE TO (b) <b>skull fracture, contusions &amp; lacerations</b>		
DUE TO (c) <b>of face, both arms broken</b>		
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"/> N: <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>Head on Auto collision</b>
---	--	---

20c. TIME OF INJURY <b>5:10pm</b>	Hour Month, Day, Year <b>2/17/61</b>
--------------------------------------	---

20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <b>Highway 40 2 Mi.</b>	20f. CITY, TOWN, OR LOCATION <b>E. Kingdom City</b>	COUNTY <b>Callaway</b>	STATE <b>Mo</b>
---	---	--	---------------------------	--------------------

21. I attended the deceased from **5:10 P.M.** to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Denzil C. Browning, coroner</b>	22b. ADDRESS <b>Fulton, Mo</b>	22c. DATE SIGNED <b>Feb. 18-1961</b>
--	-----------------------------------	---

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>18 Feb. 61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul</b>	23d. LOCATION (City, town, or country) (State) <b>St. Louis Mo.</b>
---	--------------------------------	---	--

24. FUNERAL DIRECTOR <b>Wallace Funeral Home, Fulton, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Feb. 18-1961</b>	26. REGISTRAR'S SIGNATURE <b>Maritta Lawrence</b>
---	---	--

DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

FEB 23 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 me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed *H. R. Masure*

Licensed Embalmer No. 4996

P. O. Address Fulton, Mo.

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.