

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 1 1968 8 3

-61-005813 STATE FILE NUMBER

Registration District No. 5655 Primary Registration District No. 19 Registrar's No.

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Lawrence | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jasper | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 5655 | | Length of stay in 1b 3 yrs. 35 days | c. CITY OR TOWN Joplin Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri State Sanatorium | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1321 Wisconsin Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Betty Middle Wilma Last Lewellyn | | | 4. DATE OF DEATH Month February Day 21 Year 1961 |
| 5. SEX Female | 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 7-3-12 |
| 9. AGE (last birthday) 48 | | IF UNDER 1 YEAR Months 0 Days 0 | IF UNDER 24 HR Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Fairland, Oklahoma |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME Dave West | |
| 13b. MOTHER'S MAIDEN NAME Thelma Montgomery | | 14. NAME OF HUSBAND OR WIFE James L. Lewellyn | |
| 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 Betty W. Lewellyn Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis, Far Advanced | | | INTERVAL BETWEEN ONSET AND DEATH 9 yrs. |
| 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 checked="" 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 _____ 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 1-17-58 to 2-21-61 and last saw her alive on 2-21-61 Death occurred at 8:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) J. Lewis Yates, M.D. | | 22b. ADDRESS Mo. State Sanatorium, Mt. Vernon Mo. | 22c. DATE SIGNED 2-21-61 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 2-22-61 | 23c. NAME OF CEMETERY OR CREMATORY University of Missouri Medical School | 23d. LOCATION (City, town, or county) (State) Columbia Mo. |
| 24. FUNERAL DIRECTOR Max L. Fossett ADDRESS Mt. Vernon Mo. | 25. DATE RECD. BY LOCAL REG. 2-22-61 | 26. REGISTRAR'S SIGNATURE H. D. Fossett | |

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 May L. Fassett

Licensed Embalmer No. 4252

P. O. Address W. Vernon, 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.