

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH - 61-015345

AMENDED **FILED APR 24 1961** Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3605** STATE FILE NUMBER

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

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis, Mo.</b>  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> COUNTY <b>Franklin</b> |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis, Mo.</b>  |  | Length of stay in lb<br><b>10 days</b>  | c. CITY OR TOWN <b>St. Clair, Mo.</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Firmin Desloge Hosp.</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>Mill Hill Road</b>   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>CALLIE CATHERINE LACK</b>  |  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>April 14, 1961</b>  |   |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 13, 1917</b>  | 9. AGE (last birthday)<br><b>43</b>   | IF UNDER 1 YEAR<br>Months Days<br><b>11 1</b>   |
| IF UNDER 24 HR<br>Hours Min.<br><b>11 1</b>   | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House-wife</b> |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>General</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Jefferson County MO</b>  | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b>  |
| 13a. FATHER'S NAME<br><b>Hugh Williams</b>  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Grace Mc Dermott</b>  |  | 14. NAME OF HUSBAND OR WIFE<br><b>Oscar Lack, st. Clair Mo.</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no no</b>   |  |   | 17. INFORMANT<br>Address <b>Oscar Lack St. Clair Mo.</b>   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchiolar Cell Carcinoma of Lung</b>   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 Mo.</b>                                      |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>163X</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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.<br>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 <b>2-24-61</b> to <b>4-14-61</b> and last saw him alive on <b>4-14-61</b><br>Death occurred at <b>5:25 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |   |   |
| 22a. SIGNATURE <b>Paul Murphy MD</b> (Degree or title)  |  |   | 22b. ADDRESS <b>508 N Grand</b>  |   | 22c. DATE SIGNED <b>4-15-61</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>Apr. 17, 1961</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Grubville, Cemetery Grubville, Mo.</b>   |  | 23d. LOCATION (City, town, or county) (State)   |   |
| 24. FUNERAL DIRECTOR<br><b>Sherwood W. Kitchell St. Clair, Mo.</b>  |  | ADDRESS   | 25. DATE RECD. BY LOCAL REG.<br><b>APR 15 1961</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Boad Smith, M.D.</b>  |   |

**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 Shemond W. Kitchell

Licensed Embalmer No. 3873

P. O. Address St. Clair, 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.