SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

C-2104416 SL 25706

5433 -61-022821

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

FILED JUN 16 1961

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY MARION

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N GRAND, ST LOUIS, MO. Length of stay in 1b 18 DAYS

c. CITY OR TOWN PALMYRA Inside Limits Yes [X] No [ ]

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETS. ADMIN. HOSPT. Inside Limits Yes [X] No [ ]

d. STREET ADDRESS (If outside, give location) BOX 26 Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First GIDEON Middle THEOPLUS Last LAIR

4. DATE OF DEATH Month JUNE Day 9 Year 1961

5. SEX MALE

6. COLOR OR RACE WHITE

7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]

8. DATE OF BIRTH 12/18/81

9. AGE (last birthday) 79 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) RETIRED FARMER

10b. KIND OF BUSINESS OR INDUSTRY FARMING

11. BIRTHPLACE (City and state or country) CARLINVILLE, ILL.

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME FRANCIS LAIR

13b. MOTHER'S MAIDEN NAME MELISSA TOSCH

14. NAME OF HUSBAND OR WIFE WILLA LAIR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I

16. SOCIAL SECURITY NO. UNK.

17. INFORMANT Address WILLA LAIR, WIDOW, SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) LOBAR PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH 5 DAYS

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c) 490x

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. [ ] Yes [X] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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 [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. VA attended the deceased from 5/22/61, to 6/9/61 and last saw XX him alive on 6/9/61

Death occurred at 8:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) DAVID W. FERGUSON M.D.

22b. ADDRESS VAH, ST. LOUIS, MO.

22c. DATE SIGNED 6/9/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 6/13/61

23c. NAME OF CEMETERY OR CREMATORY Durham Cemetery

23d. LOCATION (City, town, or county) (State) Durham, Missouri.

24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.,

25. DATE RECD. BY LOCAL REG. JUN 10 1961

26. REGISTRAR'S SIGNATURE Earl Smith M.D.

JUN 19 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_____ Signed Harry E. Monroe

Signature of Student Embalmer

Licensed Embalmer No. 4495

P. O. Address St. Louis 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.