

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039038
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

SI-14918 XC-1 502 989

9852

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9852**

FILED NOV 8 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Length of stay in lb <u>2 Hrs. 45 Mins.</u>	c. CITY OR TOWN <u>Granite City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VAH, 915 NO. GRAND AVE.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2644 Highway 67</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEWIS OLIVER</u>			4. DATE OF DEATH Month Day Year <u>10/24/61</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/11/92</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED.</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>69</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>GRAHAM, KENTUCKY, U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>SAM OLIVER</u>		13b. MOTHER'S MAIDEN NAME <u>LOUCINDY DOSIS</u>	14. NAME OF HUSBAND OR WIFE <u>-----</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WW-I</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>LOGAN OLIVER (SON) SEE # 2</u>		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) <u>LOBAR PNEUMONIA</u> DUE TO (b) <u>CHRONIC LUNG DISEASE</u> DUE TO (c) <u>527.2H</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>30 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>GIANT FOLLICULAR LYMPHOMA</u>			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 checked="" type="checkbox"/> NO <input 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>10/24/61</u> to <u>10/24/61</u> and last saw him <u>OK</u> alive on <u>10/24/61</u> Death occurred at <u>2:45 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Marshall Sparabey</u>		22b. ADDRESS <u>VAH, ST. LOUIS, MO.</u>	22c. DATE SIGNED <u>10/24/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>10-27-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill</u>	23d. LOCATION (City, town, or county) (State) <u>Edwardsville Twp. Illi</u>
24. FUNERAL DIRECTOR <u>Francis J. Dekey</u>	ADDRESS <u>Madison Ill.</u>	25. DATE RECD. BY LOCAL REG. <u>OCT 25 1961</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

OK. Cause of Death: Chronic Lung Disease. Death 10/24/61.

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 *James J. Lahey*

Licensed Embalmer No. 2792

P. O. Address Madison Illinois

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.