

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041690

STATE FILE NUMBER

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 190

AMENDED

FILED DEC 13 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Macon		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Macon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Macon		c. CITY OR TOWN Macon	
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 Samaritan Hospital		d. STREET ADDRESS (If outside, give location) 211 Pearl	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Catherine Lyng			4. DATE OF DEATH Month Day Year Nov. 16 1961
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Unknown
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR. Months Days Hours Min.
11. BIRTHPLACE (City and state or country) Ireland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Michael Lyng		13b. MOTHER'S MAIDEN NAME Mary Coogan	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Michael Lyng Macon, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 2 Wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1 yr Constipation Weakened following Mastectomy, Breast			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 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 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>11/8/61</u> to <u>11/16/61</u> and last saw her/him alive on <u>11/14/61</u> Death occurred at <u>10:00 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) James E. Campbell, M.D.		22b. ADDRESS Macon, Mo.	22c. DATE SIGNED 11/18/61 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/18/1961	23c. NAME OF CEMETERY OR CREMATORY St. Charles	23d. LOCATION (City, town, or county) Bevier Mo.
24. FUNERAL DIRECTOR ADDRESS H. Lester Bram Macon, Mo.	25. DATE RECD. BY LOCAL REG. 12/9/61	26. REGISTRAR'S SIGNATURE Kathleen Neely	

FEB 15 1962

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 Philip E. Bram, Student Embalmer No. 643

working under my personal supervision.

Student Philip E. Bram
Signature of Student Embalmer

Signed R. Lester Bram

Licensed Embalmer No. 4472

P. O. Address Mason, 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.