

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-003361

STATE FILE NUMBER

AMENDED

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 63

FILED FEB 14 1962

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY St. Francois		b. CITY (If outside corporate limits, give TOWNSHIP only) Bonne Terre		a. STATE Missouri		b. COUNTY St. Francois		
OR TOWN		Length of stay in 1b 1 hour		c. CITY OR TOWN Frankclay		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Bonne Terre Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				
First Belinda		Middle Elaine		Last Lawson		Month February		
Day 7th.		Year 1962						
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 Oct. 6, 1961	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR		
				Months 4	Days 1	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY		
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13a. FATHER'S NAME Lester Lawson, Sr.			13b. MOTHER'S MAIDEN NAME Vinnie Mae Graham			14. NAME OF HUSBAND OR WIFE ---		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Lester Lawson, Sr. Frankclay, Mo.			
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) DEHYDRATION + Circulatory Collapse							3 hrs	
DUE TO (b) ACUTE GASTRO-ENTERITIS							3 days	
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 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>1-7-62</u> , to <u>1-7-62</u> and last saw her ^{him} alive on <u>1-7-62</u>		Death occurred at <u>9:30A</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) C. E. Coyleton M.D.				22b. ADDRESS Waxminston Mo		22c. DATE SIGNED 2-9-62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/9/1962		23c. NAME OF CEMETERY OR CREMATORY Adams Cemetery		23d. LOCATION (City, town, or county) (State) Frankclay, Missouri		
24. FUNERAL DIRECTOR C.Z. Boyer & Son			ADDRESS Desloge, Mo		25. DATE RECD. BY LOCAL REG. Feb 9, 1962		26. REGISTRAR'S SIGNATURE Ether Rudloff	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 B. T. Boyer

Licensed Embalmer No. 3660

P. O. Address Deerloye 70

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.