

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-030245

STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 388

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 10 1962	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Cape Girardeau</u></p> <p>b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u> Length of stay in lb <u>2 yrs.</u></p> <p>c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Rogers Nursing Home</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u></p> <p>c. CITY OR TOWN <u>Rural Leemo Kelso Pop.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>2 miles East of Leemo</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED First Middle Last <u>FRED MALCOLM LANCE</u></p>	
<p>4. DATE OF DEATH Month Day Year <u>Sept 2, 1962</u></p>	
<p>5. SEX <u>Male</u></p>	<p>6. COLOR OR RACE <u>White</u></p>
<p>7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>Dec 10, 1875</u></p>
<p>9. AGE (last birthday) <u>87</u></p>	<p>IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Barber</u></p>	<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Barbering</u></p>
<p>11. BIRTHPLACE (City and state or country) <u>Trisco, Indiana</u></p>	<p>12. CITIZEN OF WHAT COUNTRY <u>USA</u></p>
<p>13a. FATHER'S NAME <u>John Wm Lance</u></p>	<p>13b. MOTHER'S MAIDEN NAME <u>Doni Know</u></p>
<p>14. NAME OF HUSBAND OR WIFE</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>unk</u></p>	<p>16. SOCIAL SECURITY NO. <u>Doni Know</u></p>
<p>17. INFORMANT <u>H. M. Russell Lance</u> Address <u>55th Ave, Ill.</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p style="text-align: center;">PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Congestive failure</u></p> <p style="text-align: center;">DUE TO (b) <u>Arteriosclerotic Heart Disease</u></p> <p style="text-align: center;">DUE TO (c)</p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p> <p style="text-align: center;">PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pneumonia</u></p> <p style="text-align: center;">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</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p>20. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year.</p>	
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>
<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>	
<p>21. I attended the deceased from <u>no attendance at time of death</u> and last saw him alive on <u>7 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE (Degree or title) <u>[Signature]</u></p>	<p>22b. ADDRESS <u>Leemo, Mo</u></p>
<p>22c. DATE SIGNED <u>9/5/62</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>	<p>23b. DATE <u>Sept 4, 1962</u></p>
<p>23c. NAME OF CEMETERY OR CREMATORY <u>Lighten Cemetery</u></p>	<p>23d. LOCATION (City, town, or county) (State) <u>Leemo, Missouri</u></p>
<p>24. FUNERAL DIRECTOR <u>BISPLINGHOFF FUNERAL HOME</u> ADDRESS <u>Leemo, Mo</u></p>	<p>25. DATE RECD. BY LOCAL REG. <u>Sept 7-62</u></p>
<p>26. REGISTRAR'S SIGNATURE <u>[Signature]</u></p>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

VS 300
Rev. 4/59
10168
21000
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94200
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13 1-0

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 Oliver C. Smith

Licensed Embalmer No. 4470

P. O. Address Illms, 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.