

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 24 1954

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>116</u>		PRIMARY REG. DIST. NO. <u>3020</u>		Registrar's No. <u>79</u>	
1. PLACE OF DEATH a. COUNTY <u>Franklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN <u>Washington</u>		c. LENGTH OF STAY (in this place) <u>9 yrs.</u>		c. CITY OR TOWN <u>Washington</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>				No. STREET ADDRESS (If rural, give location) <u>12.13 E. Third St. 03620</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>LYMAN</u> b. (Middle) <u>JAMES</u> c. (Last) <u>FALLIS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 14 1954</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Nov. 6, 1896</u>	
9. AGE (In years last birthday) <u>57</u>		10. MONTHS <u>6</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Marshalltown, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Asst. Service Officer Veterans Affairs</u>				10b. KIND OF BUSINESS OR INDUSTRY _____			
13a. FATHER'S NAME <u>Benjamin G. Fallis</u>			13b. MOTHER'S MAIDEN NAME <u>Minnie Mae Keith</u>			14. NAME OF HUSBAND OR WIFE <u>Mayer Fallis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) <u>Yes U.S. #1</u>		16. SOCIAL SECURITY NO. <u>489-28-0022</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Mayer Fallis, Washington, Mo.</u>			
18. CAUSE OF DEATH* Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION <u>metastasis</u> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma origin Recto-Sigmoid 1 year</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS <u>Atherosclerosis, premature hypertension, bronchial asthma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>					
19a. DATE OF OPERATION <u>25 July 53</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma - Recto sigmoid</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>154X</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>July 1953</u> , to <u>14 May, 1954</u> , that I last saw the deceased alive on <u>14 May, 1954</u> , and that death occurred at <u>11:50P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Wm R Richardson M.D.</u>				23b. ADDRESS <u>Union, Mo</u>		23c. DATE SIGNED <u>16 May 54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>May 18, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>5/17/54</u>		REGISTRAR'S SIGNATURE <u>Z. J. Newman</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>99-0 Nieberg & Witt, Inc. Washington, Mo.</u>		By <u>G. H. Witt, Missouri</u>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAY 24 19

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 Lester A. Witt Student Embalmer No. _____ working under my personal supervision..

Student _____
Signature of Student Embalmer

Signed Lester A. Witt
Licensed Embalmer No. 325

P. O. Address Washington

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.

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