9208

FILED APR 9 - 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 57

1. PLACE OF DEATH
a. COUNTY Laclede
b. CITY OR TOWN Lebanon — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Wallace Hospital — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Laclede
c. CITY OR TOWN Lebanon 0532 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS 445 W. Pierce (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Otto Middle: Last: Carlson

4. DATE OF DEATH Month Mar. Day 29 Year 1957

5. SEX M 6. COLOR OR RACE W 7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] 8. DATE OF BIRTH Nov. 22, 1877 9. AGE (In years last birthday) 79 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) Hamburg, Germany 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Gustave Carlson 13b. MOTHER'S MAIDEN NAME Not known 14. NAME OF HUSBAND OR WIFE Effie Carlson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. — 17. INFORMANT Mrs. Otto Carlson, Address Lebanon, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Prostate with Metastases. — INTERVAL BETWEEN ONSET AND DEATH 2 years.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 177X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ] None
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 [ ] NOT WHILE AT WORK [ ]
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 1/21/57, to 3/29/57 and last saw her/him alive on 3/29/57
Death occurred at 11.30 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE George T. Fisher (Degree or title) M.D. 22b. ADDRESS Lebanon, Mo 22c. DATE SIGNED 3/30/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 3/31/57 23c. NAME OF CEMETERY OR CREMATORY Lebanon Cem. 23d. LOCATION (City, town, or county) (State) Lebanon, Missouri

24. FUNERAL DIRECTOR A R Palmer ADDRESS Lebanon Mo 25. DATE RECD. BY LOCAL REG. 3-30-1957 26. REGISTRAR'S SIGNATURE Nella L. May

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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Received 4-8-57

Laclede County Health Unit

File No. 57

Date Filed 4-8-57

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 Richard L. Palmer

Licensed Embalmer No. 4595

P. O. Address Lebanon, 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.