

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010633
STATE FILE NUMBER

Health,
& Welfare
Public
Service

FILED APR 1 1959 Registration District No. 316 Primary Registration District No. 4462 Registrar's No. 113

300
1-57

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Francois</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ELVINS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ELVINS</u> <u>0940</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	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) <u>LEWIS</u> First <u>Archambo</u> Middle <u>J</u> Last			4. DATE OF DEATH <u>Feb. 27-1959</u> Month <u>Feb.</u> Day <u>27</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 17, 1888</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>miner Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>miner</u>	11. BIRTHPLACE (City and state or country) <u>WASHINGTON Co. Mo. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>ELI Archambo</u>		13b. MOTHER'S MAIDEN NAME <u>Roseane Buff</u>		14. NAME OF HUSBAND OR WIFE <u>SUSIE ARCHAMBO</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>493-03-9576</u>		17. INFORMANT <u>Susie Archambo</u> Address <u>ELVINS, MO</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>200X</u>					
DUE TO (c) <u>Arteriosclerosis, generalized</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Had previous thrombosis 3 yrs ago</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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 <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u> </u>					
20d. INJURY OCCURRED WHILE AT <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>Mar 1959</u> to <u>Feb 27, 59</u> and last saw him alive on <u>Feb 27 '59</u> Death occurred at <u>1145/0</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>J. L. Foster</u> (In free or title) <u>MS</u>			22b. ADDRESS <u>Dr. Sloger Mo</u>		22c. DATE SIGNED <u>2-28-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>MAR. 2, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>K.O.F.P.</u>		23d. LOCATION (City, town, or county) (State) <u>Flat River, MO</u>
24. FUNERAL DIRECTOR <u>Raymond Caldwell</u> ADDRESS <u>Flat River, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Mar. 23, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Ethel Rudloff</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

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.

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 *R. Caldwell*

Licensed Embalmer No. *2531*

P. O. Address *Flat River*

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.