

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012311  
STATE FILE NUMBER

FILED MAY 11 1959

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 211

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>BOONIE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JASPER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>COLUMBIA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>JOPLIN</u> <u>0495</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR UNIVERSITY INSTITUTION <u>UNIVERSITY MEDICAL CENTER</u>		Length of stay in 1b <u>4 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>915 1/2 MAIN</u> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK JOHN SEWELL</u>			4. DATE OF DEATH Month Day Year <u>5 6 59</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>10-2-04</u>
9. AGE (In years last birthday) <u>54</u>		10. FUNDER 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) <u>Maintenance Dept. State Highway</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>McGEE, ARK.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13a. FATHER'S NAME <u>JAMES SEWELL</u>	
13b. MOTHER'S MAIDEN NAME <u>NANCY SHEPHERD</u>		14. NAME OF HUSBAND OR WIFE <u>MARIE SEWELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>390-0973247</u>	17. INFORMANT Address <u>Hospital Record</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>LYMPHOMA WITH INFILTRATION OF</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>ABDOMINAL VISCERA AND BRAIN</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>2021</u>			INTERVAL BETWEEN ONSET AND DEATH <u>?</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 Month, Day, Year a.m. p.m.			
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>MAY 1, 1959</u> to <u>MAY 6, 1959</u> and last saw <sup>him</sup> <u>alive</u> on <u>MAY 6, 1959</u> Death occurred at <u>12 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. Sanders</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>University Medical Center</u>	22c. DATE SIGNED <u>5-6-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5-6-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ozark Memorial Joplin Mo</u>	23d. LOCATION (City, town, or country) (State) <u>Webb City Mo</u>
24. FUNERAL DIRECTOR <u>Forbes Funeral Home</u> ADDRESS <u>Columb</u>		25. DATE RECD. BY LOCAL REG. <u>May 6 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

MAY 18 1959

JUN 10 1959

JUN 25 1959

APR 8 1960

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 Douglas P. Gorman

Licensed Embalmer No. 5037

P. O. Address Columbus, GA

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.