

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-039079

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED **F1**

Registration District No. 146

Primary Registration District No. 3026

Registrar's No. 508

**ED NOV 1 1962**

VS 300  
Rev. 4/59

DATE AMENDED

17005

27005

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1290-0

131-0

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>JACKSON</b>		a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>INDEPENDENCE</b>		c. CITY OR TOWN <b>INDEPENDENCE</b>	
Length of stay in lb <b>32 yrs.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2619 BAKER RD.</b>		d. STREET ADDRESS (If outside, give location) <b>2619 BAKER RD.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LEWIS P. CLOTHIER</b>			4. DATE OF DEATH Month Day Year <b>OCTOBER 25, 1962</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC.</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-8-1881</b>
9. AGE (last birthday) <b>80</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET. INSURANCE AGENT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE CO.</b>	11. BIRTHPLACE (City and state or country) <b>KISHWAUKEE, ILLINOIS</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13a. FATHER'S NAME <b>LEWIS CLOTHIER</b>	
13b. MOTHER'S MAIDEN NAME <b>EMMA MILLER</b>		14. NAME OF HUSBAND OR WIFE <b>GRACE WELLS CLOTHIER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES W. W. I</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>GRACE W. CLOTHIER 2619 BAKER RD. INDEP.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Adenocarcinoma left lung</b>			<b>2 yrs</b>
DUE TO (b) <b>with metastasis - generalized</b>			<b>1 yr</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)			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
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	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 a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <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 <b>Nov 21, 1962</b> to <b>10/25/62</b> and last saw <sup>her</sup> him alive on <b>10/23/62</b> Death occurred at <b>2:30 p.m.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Vance E. Lusk, M.D.</b>		22b. ADDRESS <b>10901 Anniston Rd Independence, Mo</b>	
22c. DATE SIGNED <b>10/26/62</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>10-29-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>ST. JOSEPH, MISSOURI</b>
24. FUNERAL DIRECTOR & SONS- INDEPENDENCE, MO.		25. DATE RECD. BY LOCAL REG. <b>10-27-62</b>	26. REGISTRAR'S SIGNATURE <b>Alba L. Craig</b>

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**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 J. T. Crowell

Licensed Embalmer No. 4904

P. O. Address H. C. 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.