

FILED NOV 29 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39487

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 229

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Marshall</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural - Marshall</u>	
c. LENGTH OF STAY (In this place) <u>3 days</u>		d. STREET ADDRESS (If rural, give location) <u>Marion, R 70th 27</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fitzgibbon - Hospital</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 19 - 1950</u>	
3. NAME OF DECEASED (Type or Print) <u>Nellie Ruth Cabill</u>		b. (Middle) <u>Cabill</u> c. (Last)	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 21 - 1895</u>
9. AGE (In years last birthday) <u>55-3-28</u>		9. AGE (In years) IF UNDER 1 YEAR IF UNDER 2 HRS. Months   Days   Hours   Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General House</u>	
11. BIRTHPLACE (State or foreign country) <u>Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>D S Curdiffe</u>		13b. MOTHER'S MAIDEN NAME <u>Matilda Quincy Boyd Cabill</u>	
14. NAME OF HUSBAND OR WIFE <u>Boyd Cabill</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Boyd Cabill</u>		ADDRESS <u>Marion 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Failure</u>  ANTECEDENT CAUSES DUE TO (b) <u>Left Atypical Pneumonia</u> DUE TO (c) <u>49, 0 X</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma Breast Po. 27p</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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>Nov. 10, 1948</u> , to <u>Nov. 19, 1950</u> , that I last saw the deceased alive on <u>Nov. 10, 1950</u> , and that death occurred at <u>5:30 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Robert Kennedy M.D.</u>		23b. ADDRESS <u>Marshall Mo</u>	
23c. DATE SIGNED <u>11-20-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		24b. DATE <u>Nov. 21-50</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Swanwick Memorial</u>		24d. LOCATION (City, town, or county) (State) <u>Marshall Mo</u>	
DATE REC'D BY LOCAL REG. <u>Nov. 26-1950</u>		REGISTRAR'S SIGNATURE <u>Sidney J. Gray</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Jones &amp; Sager</u>		ADDRESS <u>Mo</u>	

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

RECEIVED

11/29/80

DISTRICT HEALTH OFFICE No. 3

District File Number \_\_\_\_\_

Date Filed 11/29/80

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 \_\_\_\_\_  
Student Embalmer

Signed

*James E. Jones*

Licensed Embalmer No. 23/43

P. O. Address. Slater M

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 this body is not embalmed, fact should be so stated above.