

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44536

STATE FILE NUMBER

FILED JAN 2 1957

Registration District No. 354 Primary Registration District No. 4519 Registrar's No. 96

|  |                           |   |  |   |   |  |   |
|--|---------------------------|---|--|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>TEXAS</u>  |                           |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MO.</u> b. COUNTY <u>TEXAS</u> |   |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>CABOOL</u>   |                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  | c. CITY OR TOWN <u>CABOOL</u>   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION  |                           |   | Length of stay in lb<br><u>4 yrs.</u>  |   | d. STREET ADDRESS (If outside, give location)<br><u>8 mi. So.</u> |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>EP SA</u> Middle <u>OS BORN</u> Last <u>OS BORN</u>  |                           |   |  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>22</u> Year <u>56</u>  |   |  |   |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>9-7-1878</u>   |   | 9. AGE (In years last birthday)<br><u>78</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country)<br><u>ILLINOIS</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |   |
| 13. FATHER'S NAME<br><u>LEWIS BAIL</u>   |                           |   |  | 14. MOTHER'S MAIDEN NAME<br><u>UNKNOWN</u>  |   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>   |                           | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |  | 17. INFORMANT<br><u>Jake Jones</u>  |   | Address<br><u>Cabool, Mo.</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized metastasis</u><br>DUE TO (b) <u>Malignant Melanoma of vulva</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)<br><u>176X</u> |                           |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 mon.</u><br><u>1 year.</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<br>Hour _____ Month _____ Day _____ Year _____<br>a. m. _____ p. m. _____  |                           |   |  |   |   |  |   |
| 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. attended the deceased from <u>3/13/56</u> to <u>12/22/56</u> and last saw her <u>alive</u> on <u>12/22/56</u><br>Death occurred at <u>3:30 p.</u> m. on the date stated above; and to the best of my knowledge, from the causes stated.  |                           |   |  |   |   |  |   |
| 22a. SIGNATURE (Degree or title)<br><u>J. L. Spear M.D.</u>  |                           |   |  | 22b. ADDRESS<br><u>Cabool, Mo</u>   |   | 22c. DATE SIGNED<br><u>12/26/56</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                           | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City, town, or county) (State)                     |  |   |
| <u>BURIAL</u>  |                           | <u>12-24-56</u>   | <u>CABOOL</u>  |   | <u>CABOOL MO.</u>   |  |   |
| 24. FUNERAL DIRECTOR<br><u>Elliott - Senty, Cabool, Mo.</u>  |                           |   |  | 25. DATE RECD. BY LOCAL REG.<br><u>12-28-56</u>   |   | 26. REGISTRAR'S SIGNATURE<br><u>Gaynell Cunningham</u>                               |   |

(Licensed Embalmer's Statement on Reverse Side)

300  
-56  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All symptoms were as stated. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

MEDICAL CERTIFICATION

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.....  
*James L. Gentry*

Licensed Embalmer No. *471*

P. O. Address *Calool, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.