

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED FEB 19 1957

STATE FILE NUMBER

4158

Registration District No. 93

Primary Registration District No. 4154

Registrar's No. 57-15

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Dade</u>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Dade</u>                       |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Greenfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   | c. CITY OR TOWN <u>Greenfield</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 <u>52 N. Main St.</u> Length of stay in 1b <u>12 yrs.</u>   |   | d. STREET ADDRESS (If outside, give location) <u>52 N. Main St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Lou</u> Middle <u>-</u> Last <u>Meng</u>  |   |  | 4. DATE OF DEATH<br>Month <u>Feb.</u> Day <u>10</u> Year <u>1957</u> |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 29, 1865</u>                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>   | 9. AGE (In years last birthday) <u>91</u>                            |
| 11. BIRTHPLACE (City and state or country) <u>Dade Co., Mo.</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |  |
| 13. FATHER'S NAME <u>Columbus Talbutt</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Amanda Allison</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or date of service) <u>None</u>   | 16. SOCIAL SECURITY NO. <u>None</u>   | 17. INFORMANT <u>Mrs. Skinner Collier</u> Address <u>Greenfield, 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>Embolism of spleen.</u><br>DUE TO (b) <u>Bronchial pneumonia</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(a) _____ |   |  | INTERVAL BETWEEN ONSET AND DEATH _____                               |
| 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.) <u>0</u>  |  |
| 20c. TIME OF INJURY. Hour _____ a. m. _____ p. m. Month _____ Day _____ Year _____  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 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 <u>Jan 27-57</u> to <u>Feb. 10, 1957</u> and last saw her alive on <u>2-9-57</u> . Death occurred at <u>2:15</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.  |   |  |  |
| 22a. SIGNATURE (Degree or title) <u>Th. O. Cowan M.D.</u>   |   | 22b. ADDRESS <u>Greenfield, Mo.</u>  | 22c. DATE SIGNED <u>2-12-57</u>                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE <u>Feb. 12, 1957</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenfield Cem.</u>  | 23d. LOCATION (City, town, or county) (State) <u>Greenfield, Mo</u>  |
| 24. FUNERAL DIRECTOR <u>J. C. Canada, Greenfield, Mo.</u> ADDRESS _____   |   | 25. DATE RECD. BY LOCAL REG. <u>2-12-57</u>  | 26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>                        |

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300 1-56

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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. C. Canada* .....  
Licensed Embalmer No. 419

P. O. Address .....

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

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.