

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9562

STATE FILE NUMBER

FILED MAR 18 1957

Registration District No. 267 Primary Registration District No. 4314 Registrar's No. _____

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

1. PLACE OF DEATH a. COUNTY <u>Ozark</u> <u>0770</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ozark</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Bakersfield</u> OR TOWN <u>Bakersfield</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Bakersfield</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>✓</u>			Length of stay in 1b <u>1</u>	d. STREET ADDRESS <u>R 2 D</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Grace Truman De Laun</u> First <u>Truman</u> Middle <u>De Laun</u> Last <u>De Laun</u>			4. DATE OF DEATH <u>2-24-1957</u> Month <u>2</u> Day <u>24</u> Year <u>1957</u>		
5. SEX <u>2</u>	6. COLOR OR RACE <u>W</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>1-21-1889</u>	9. AGE (In years last birthday) <u>68</u> IF UNDER 1 YEAR Month <u>1</u> Day <u>13</u> IF UNDER 24 HRS. Hours <u>13</u> Min. <u>00</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>✓</u>	11. BIRTHPLACE (City and state or country) <u>Ozark Co, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>P. M. Ferguson</u>			14. MOTHER'S MARDEN NAME <u>Charoline Baker</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Yes</u>	17. INFORMANT <u>Grace Cullen, West Plains Mo</u> Address _____		
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>Cancer Breast</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>with generalized metastases</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) _____					INTERVAL BETWEEN ONSET AND DEATH <u>4 years</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 _____ 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. I attended the deceased from <u>11/26-56</u> to <u>2-24-57</u> and last saw her <u>her</u> alive on <u>12-4-56</u> Death occurred at <u>7:15 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>G B Stoll M.D.</u> (Degree or title)			22b. ADDRESS <u>West Plains</u>		22c. DATE SIGNED <u>3/8/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>2/27-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bakersfield</u>	23d. LOCATION (City, town, or county) <u>Bakersfield Mo</u>		(State)
24. FUNERAL DIRECTOR <u>Robertson West Plains Mo</u>		ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>3-18-57</u>	26. REGISTRAR'S SIGNATURE <u>Byrd H. Bridger</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 *L. S. Roberts*

Licensed Embalmer No. *343*

P. O. Address *West Hill*

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.