

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41153

STATE FILE NUMBER

FILED DEC 2 - 1957

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 463

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Audrain	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Vandalia Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Elizabeths Hospital Length of stay in lb		d. STREET ADDRESS 414 North Jefferson (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Casewell Last Speer			4. DATE OF DEATH Month Nov Day 16 , Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1871
9. AGE (In years last birthday) 86		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher		10b. KIND OF BUSINESS OR INDUSTRY Public Schools	11. BIRTHPLACE (City and state or country) Waynes County, West Virginia, US.
12. CITIZEN OF WHAT COUNTRY? US.		13. FATHER'S NAME James Casewell Speer	
14. MOTHER'S MAIDEN NAME Leah Frances Plymale		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs G. L. Arend, Downs, Kansas 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) uremia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) blepharospasmia, terminal DUE TO (c) benign prostatic hypertrophy with bladder distention			INTERVAL BETWEEN ONSET AND DEATH 4 days 2 days 60 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) granulosa adenocarcinoma, arteriosclerotic disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) 610X	
20c. TIME OF INJURY Hour a. m. Month p. m. 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 Vandalia, Mo	
21. I attended the deceased from Sept 10 57 to November 16, 1957 and last saw her alive on 11/16/57 Death occurred at 7:50 p m m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Carroll Cherene MD (Doctor or title)	
22b. ADDRESS Vandalia Mo		22c. DATE SIGNED 11/21/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov 19, 1957	
23c. NAME OF CEMETERY OR CREMATORY Laddonia Cemetery		23d. LOCATION (City, town, or county) (State) Laddonia, Missouri	
FUNERAL DIRECTOR William B Waters ADDRESS Vandalia, Mo.		25. DATE RECD. BY LOCAL REG. 11-25-57	
25. REGISTRAR'S SIGNATURE M. E. M. Lucke By W. C. Fisher			

(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 casually related. Coroner cannot certify to a death due to natural causes.
Securing the medical certification in the specific manner required by 1957 regulations.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

RECEIVED NOV 29 1957
MARION CO. HEALTH DEPT.
DATE FILED NOV 29 1957

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 *William B. Waters*

Licensed Embalmer No. *416*

P. O. Address *Vandalia,*

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.