

Dr. J. C. Daniel

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-015198

STATE FILE NUMBER

FILED APR 25 1958

Registration District No. 072 Primary Registration District No. 4403 Registrar's No. 14

300

1-57

780

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

1. PLACE OF DEATH a. COUNTY <u>Combs</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Combs</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Steele</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Steele</u> 0780 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) <u>Franklin</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rosa Lee Legault</u>		4. DATE OF DEATH Month Day Year <u>3-31-58</u>	
5. SEX <u>F</u>	6. COLOR OF 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>1-9-1892</u>
9. AGE (In years last birthday) <u>66</u>		FUNDER 1 YEAR Months Days Hours Min. <u>2 22</u>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home work</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>unknown</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>unknown</u>	
13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Bill George</u> Address <u>Steele Mo</u>
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>Carcinoma urinary Bladder</u> DUE TO (b) _____ 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>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 Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 <u>1810</u>	
21. I attended the deceased from <u>8-8-57</u> to <u>3-31-58</u> and last saw <sup>her</sup> / <sub>him</sub> alive on <u>3-31-58</u> Death occurred at <u>11:30 P</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>H. G. McDaniel MD</u> (Degree or title)		22b. ADDRESS <u>Steele Mo</u>	
22c. DATE SIGNED <u>4-2-58</u>		22d. DATE OF DEATH	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-2-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>	23d. LOCATION (City, town, or county) (State) <u>Steele Mo</u>
24. FUNERAL DIRECTOR <u>Desmond Lind C Steele</u> ADDRESS		25. DATE RECD BY LOCAL REG. <u>4-2-58</u>	
26. REGISTRAR'S SIGNATURE <u>H. G. McDaniel</u>		26. REGISTRAR'S SIGNATURE	

4-112-58

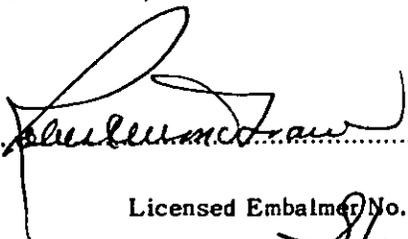
APR 23 1958

PEMISCOT COUNTY HEALTH DEPARTMENT  
COURTHOUSE PHONE 79  
CARUTHERSVILLE, MO.

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  .....  
Licensed Embalmer No. 4732  
P. O. Address  .....

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.