

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-022486

STATE FILE NUMBER

FILED JUL 14 1958 Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 77

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u>		c. CITY OR TOWN <u>Brookfield</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>100 East Adams</u>		d. STREET ADDRESS <u>100 East Adams</u> (If outside, give location) Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Length of stay in 1b <u>6 years</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Lena</u> First <u>B.</u> Middle <u>Cheek</u> Last	4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1958</u>
---	---

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 29, 1875</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</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>Homemaker</u>	11. BIRTHPLACE (City and state or country) <u>Dallatin, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	---	---	---

13. FATHER'S NAME <u>Andrew Jackson Haggerty</u>	14. MOTHER'S MAIDEN NAME <u>Elizabeth Chrisman</u>
---	---

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. <u>none</u>	17. INFORMANT <u>D.F. Cheek, Brookfield, 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 of ovary left</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	1750
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary occlusion</u>		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.)
---	--

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>1956</u> to <u>July 3-1958</u> and last saw her alive on <u>July 3-1958</u> Death occurred at <u>6:10 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <u>W.B. Simpson, MD</u>	22b. ADDRESS <u>Brookfield Mo</u>	22c. DATE SIGNED <u>7/4/58</u>
---	--------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>July 5, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Brookfield, Missouri</u>
---	----------------------------------	---	--

24. FUNERAL DIRECTOR <u>Hill Funeral Home, Brookfield, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7-7-58</u>	26. REGISTRAR'S SIGNATURE <u>Katharine Johnson</u>
---	---	---

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service
300 1-56
All information on this certificate must be typed in black ink or ribbon. No symbols 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 *Gerald F. Wa*.....

Licensed Embalmer No. *41*

P. O. Address *Brown*

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.