

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027938
STATE FILE NUMBER

FILED JUL 23 1958 Registration District No. 340 Primary Registration District No. 4503 Registrar's No. 65

S. 300
1-57

| | | | | | |
|---|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Stoddard | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Stoddard | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bernie | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Bernie | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Family home | | Length of stay in lb ---- | d. STREET ADDRESS (If outside, give location) West part of town | | Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Lela Middle Catherine Last Esterline | | | 4. DATE OF DEATH Month July Day 10 , Year 1958 | | |
| 5. SEX Female | 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 8, 1929 | 9. AGE (In years last birthday) 29 | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (City and state or country) McGee, Missouri | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13a. FATHER'S NAME Oades Adams | | 13b. MOTHER'S MAIDEN NAME Wilma Howell | | 14. NAME OF HUSBAND OR WIFE Howard Glen Esterline | |
| 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. 493-30-8145 | 17. INFORMANT Address Mr. Howard Esterline Bernie, Mo. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Non malignant tumor of the Brain | | | | | INTERVAL BETWEEN ONSET AND DEATH Unknown |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ | | | | | 223X |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | 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 <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 Sept. 12, 1957 to July 10, 1958 and last saw her alive on July 8, 1958 Death occurred at 6:45 P.m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE F. O. K. Clay D.O. | | 22b. ADDRESS Bernie, Missouri | | 22c. DATE SIGNED 7-14-58 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 7-13-58 | 23c. NAME OF CEMETERY OR CREMATORY Bernie, Cemetery | | 23d. LOCATION (City, town, or county) (State) Bernie, Mo. |
| 24. FUNERAL DIRECTOR Duffie-Rainey Bernie, Mo. | | | 25. DATE RECD. BY LOCAL REG. 7-17-58 | 26. REGISTRAR'S SIGNATURE Valera D. Jenkins | |

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Raymond L. Duff*

Licensed Embalmer No. *4798*
P. O. Address. *Berrie, Md*

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.