

Health,  
& Welfare  
Public  
Service  
040  
300  
1-57

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-031653  
STATE FILE NUMBER

FILED SEP 25 1958 Registration District No. 10 Primary Registration District No. 5035 Registrar's No. 196

1. PLACE OF DEATH a. COUNTY <b>Audrain</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Audrain</b> Mo	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Centralia, Mo</b>		c. CITY OR TOWN <b>Centralia, Mo</b> 0040	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>XXXXXXXXXX</b>		d. STREET ADDRESS (If outside, give location) <b>R R</b>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>Elizabeth D Egelston</b>			4. DATE OF DEATH Month Day Year <b>9 28 1958</b>		
-----------------------------------------------------------------------------------------	--	--	--------------------------------------------------------	--	--

5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 14, 1870</b>	9. AGE (In years last birthday) <b>88</b>	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) <b>at home</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>home-making</b>	11. BIRTHPLACE (City and state or country) <b>California</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
---------------------------------------------------------------------------------------------------------------	---------------------------------------------------------	-----------------------------------------------------------------	----------------------------------------------

13a. FATHER'S NAME <b>Samuel Jarman</b>	13b. MOTHER'S MAIDEN NAME <b>XXXXXXXX</b>	14. NAME OF HUSBAND OR WIFE <b>Walter Egelston</b>
--------------------------------------------	----------------------------------------------	-------------------------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mrs Will Adams</b> Address <b>Centralia, Mo R R</b>
-----------------------------------------------------------------------------------------------------------	----------------------------------------	-------------------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adeno-C. carcinoma of colon with wide-spread metastasis.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1538</b>
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) <b>Arteriosclerotic heart disease.</b>		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 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
-----------------------------------------------------------	---------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	------------------------------	--------	-------

21. I attended the deceased from Death occurred at <b>8:10 a.m.</b> to <b>9/12/58</b> and last saw her alive on <b>9/12/58</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

22a. SIGNATURE <b>Robert L. Ward M.D.</b> (Degree or title)	22b. ADDRESS <b>Centralia, Missouri</b>	22c. DATE SIGNED <b>9/13/58</b>
----------------------------------------------------------------	--------------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>sept 14, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Antioch</b>	23d. LOCATION (City, town, or county) (State) <b>Randolph Co Mo</b>
------------------------------------------------------------	-----------------------------------	------------------------------------------------------	------------------------------------------------------------------------

24. FUNERAL DIRECTOR <b>Fred A Thompson</b> ADDRESS <b>Madison Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Sept 14-1958</b>	26. REGISTRAR'S SIGNATURE <b>Bertha Steely</b>
--------------------------------------------------------------------------	-----------------------------------------------------	---------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 No. 1040-10-1-57

society member, etc., must use only standard nomenclature on death. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Wm. Fred A. Leaf* .....

Licensed Embalmer No. *3282*  
P. O. Address *Madison, Wis.*

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.