

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-033122  
STATE FILE NUMBER

FILED OCT 7 1958 Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 407

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY OR TOWN <u>Independence</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Independence</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
1. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>800 E. Herford</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>800 E. Herford</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Heleen</u> Middle <u>Lucille</u> Last <u>Caudeu</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>26</u> Year <u>1958</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug-19-1900</u>	9. AGE (In years last birthday) <u>58</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Homemaker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (City and state or country) <u>Newtown 9</u>	12. CITIZEN OF WHAT COUNTRY? <u>usa</u>
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13a. FATHER'S NAME <u>George William</u>	13b. MOTHER'S MAIDEN NAME <u>Ida Franklin</u>	14. NAME OF HUSBAND OR WIFE <u>Archie Caudeu</u>
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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>Archie Caudeu</u> Address <u>Indep. Mo</u>
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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>Pulmonary edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sept 23, 1958</u> <u>1953</u> <u>1948</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Carcinoma of Liver</u>	
	DUE TO (c) <u>Hypertension</u> <u>1561</u>	
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.)
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20c. TIME OF INJURY Hour <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
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21. I attended the deceased from Jan 1958 to Sept 26, 1958 and last saw her alive on Sept 26, 1958  
Death occurred at \_\_\_\_\_ m of the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>F. E. Fersch</u> (Degree or title) <u>MO</u>	22b. ADDRESS <u>Harrisonville Mo</u>	22c. DATE SIGNED <u>Sept 30, 1958</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-29-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mound Grove</u>	23d. LOCATION (City, town, or county) (State) <u>Independence - Missouri</u>
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24. FUNERAL DIRECTOR <u>Roland R. Speaks</u> ADDRESS <u>Indep. Mo</u>	25. DATE RECD. BY LOCAL REG. <u>10-4-1958</u>	26. REGISTRAR'S SIGNATURE <u>James Keagy</u>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

8989 7 1 AON

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 *Rollie Fessel* .....

Licensed Embalmer No. *4890* .....

P. O. Address *Indep. Mo.* .....

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.