

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043138

STATE FILE NUMBER

FILED JAN 5 1958 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 407

300
-57

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Adair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kirksville ⁰⁰¹³ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Grim-Smith		Length of stay in lb	d. STREET ADDRESS 602 E. Harrison (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) Lola Montez Shulze			4. DATE OF DEATH Dec. 29, 1958				
First	Middle		Last	Month	Day		Year

5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1889	9. AGE (In years (If birthday) 69)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
-----------------	---------------------------	---	---------------------------------------	--	---------------------------	--------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Kirksville, Mo.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
---	---	---	--

13a. FATHER'S NAME Charles L. Allred	13b. MOTHER'S MAIDEN NAME Nellie Spry	14. NAME OF HUSBAND OR WIFE Bert R. Shulze
---	--	---

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. 494-20-5224B	17. INFORMANT Mr. Bert R. Shulze, Kirksville, Mo.	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) Carcinomatosis.		INTERVAL BETWEEN ONSET AND DEATH 3 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Carcinoma of the cervix.	3 1/2 years
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 171X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
---	--	--

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 o.m. Month, Day, Year p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 8-13-56 to 12-29-58 and last saw her alive on 12-29-58 Death occurred at 11:50 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <i>J. B. Jones</i> (Degree or title)	22b. ADDRESS 201 E. Patterson Kirksville, Missouri	22c. DATE SIGNED 12-30-58
---	---	----------------------------------

23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)	23b. DATE Dec. 31, 1958	23c. NAME OF CEMETERY OR CREMATORY Llewellyn C emetery	23d. LOCATION (City; town, or county) Kirksville, Mo.	(State)
---	--------------------------------	---	--	---------

24. FUNERAL DIRECTOR <i>Paul H. Jones</i> ADDRESS Kirksville, Mo.	25. DATE RECD. BY LOCAL REG. 12-31-58	26. REGISTRAR'S SIGNATURE <i>Norris W. Pattiff</i>
--	--	--

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION
All diseases in Part I must be causally related.
J. B. Jones, M.D.

APR 10 1958

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 *George W. Davald*

Licensed Embalmer No. *4799*
P. O. Address *Kukawala*

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.