

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045159

STATE FILE NUMBER

FILED DEC 29 1958

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 163

1. PLACE OF DEATH a. COUNTY <u>Pike</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>	
b. CITY OR TOWN <u>Louisiana</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Louisiana</u> ⁰⁸²¹ 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>Pike County Hospital</u> Length of stay in 1b <u>18 years</u>		d. STREET ADDRESS (If outside, give location) <u>1101 Tennessee</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>BUNICE MARIA GREEN</u>			4. DATE OF DEATH Month Day Year <u>Dec 13, 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>Feb. 3, 1903</u>
9. AGE (In years last birthday) <u>55</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during a most of working life, even if retired) <u>Office Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursery</u>	11. BIRTHPLACE (City and state or country) <u>Miland Ill</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>W. C. Rice</u>	
13b. MOTHER'S MAIDEN NAME <u>L. V. South</u>		14. NAME OF HUSBAND OR WIFE <u>David Green</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>488-24-8938</u>	
17. INFORMANT <u>David Green</u> Address <u>Louisiana Mo.</u>		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>Generalized carcinomatosis</u> DUE TO (b) <u>Carcinoma of left breast</u> DUE TO (c) <u>with metastasis to brain</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>-----</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>3 months</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.) <u>-----</u>	
20c. TIME OF INJURY . Hour Month, Day, Year a.m. p.m. <u>-----</u>		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.) <u>-----</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>-----</u>	
21. I attended the deceased from <u>12/13/58</u> and last saw her ^{her} _{him} alive on <u>12/13/58</u> Death occurred at <u>10:30 P</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Chas. H. Lemellen M.D.</u>		22b. ADDRESS <u>Louisiana, Missouri</u>	
22c. DATE SIGNED <u>12-15-58</u>		23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>12/16/58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chippianock</u>	
23d. LOCATION (City, town, or county) <u>Rock Island Ill</u>		23e. (State)	
24. FUNERAL DIRECTOR <u>Home Funeral Home Louisiana</u> ADDRESS		25. DATE REC'D. BY LOCAL REG. <u>12-22-58</u>	
REGISTRAR'S SIGNATURE <u>Bernice Collier</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

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 *J. B. Sterne*

Licensed Embalmer No. *4039*

P. O. Address *Louisiana*

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.