

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002433  
STATE FILE NUMBER

FILED FEB 11 1959

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 16

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 (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LOUISIANA</u>		c. CITY OR TOWN <u>SPENCERBURG</u> <u>08-20</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PIKE Co. HOSPITAL</u>		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) First <u>FLOSSIE</u> Middle <u>VIRDEN</u> Last <u>VIRDEN</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>7</u> Year <u>1959</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>APRIL 23-1918</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>GREEN Co. ILLINOIS</u>
13a. FATHER'S NAME <u>SAMUEL SPEAGLE</u>		13b. MOTHER'S MAIDEN NAME <u>DORA McCLENNING</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>		17. INFORMANT <u>Miss Doris Virden Spencerburg 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 Carcinoma</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Dec. 1 - 19</u> to <u>Feb. 6, 1959</u> and last saw her alive on <u>Feb 6, 1959</u> Death occurred at <u>1:30 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>E. P. Hansen D.O. 2</u>		22b. ADDRESS <u>Frankford, Mo.</u>	
22c. DATE SIGNED <u>2-9-59</u>		23a. NAME OF CEMETERY OR CREMATORY <u>North Dickson</u>	
23b. LOCATION (City, town, or county) (State) <u>Frank County Rural Illinois</u>		23c. DATE RECD. BY LOCAL REG. <u>Feb 9. 59</u>	
24. FUNERAL DIRECTOR <u>J.P. Megaw Frankford, Mo.</u>		25. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>	

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 *Jose Fields Megawon* .....

Licensed Embalmer No. *4092* .....  
P. O. Address *Funford, N.C.* .....

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.