

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004476

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 82

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>NEW MADRID</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Lilbourn</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University Hospital</u>		Length of stay in lb <u>1 day</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ADA</u> Middle <u>MILAN</u> Last <u>DANDRIDGE</u>			4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>1959</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</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>11-3-22</u>	9. AGE (In years last birthday) <u>35</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>Como, Mississippi</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>WALTER MILAN</u>		13b. MOTHER'S MAIDEN NAME <u>Beulah Burnett</u>		14. NAME OF HUSBAND OR WIFE <u>LEE DANDRIDGE</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>NONE</u>		17. INFORMANT <u>Hospital Record</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>Intestinal Obstruction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Approx. 5 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) <u>Primary Carcinoma of Cervix</u>			
DUE TO (c) <u>Abdominal Carcinomatosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>171X</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 WORK <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 <u>2/13/59</u> to <u>2/14/59</u> and last saw <sup>her</sup> <del>him</del> alive on <u>2/14/59</u> Death occurred at <u>9:30</u> A. M. on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE (Degree or title) <u>H. M. Williams, M.D.</u>			22b. ADDRESS <u>90 Univ. of Mo. Medical Center</u>			22c. DATE SIGNED <u>2/14/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/20/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sanatopia</u>		23d. LOCATION (City, town, or county) (State) <u>Sanatopia Miss.</u>		

24. FUNERAL DIRECTOR <u>Mrs. Stuart Parker, Columbia, Mo.</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>Feb 17 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u>	
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

