

with  
Mortuary  
office  
service

*Dr. Halcomb*

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006569

STATE FILE NUMBER

FILED MAR 6 1959

Registration District No. 272

Primary Registration District No. 4403

Registrar's No. 18

1. PLACE OF DEATH a. COUNTY: <i>Franklin</i>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE: <i>Missouri</i> b. COUNTY: <i>Franklin</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: <i>Steele</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN: <i>Steele</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b <i>43 yrs</i>	d. STREET ADDRESS (If outside, give location) <i>East Main</i>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First: <i>Robert</i> Middle: <i>Lee</i> Last: <i>Donaldson</i>			4. DATE OF DEATH Month: <i>2</i> Day: <i>18</i> Year: <i>59</i>		
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-26-1878</i>	9. AGE (In years last birthday) <i>80</i>	IF UNDER 1 YEAR: Months: <i>4</i> Days: <i>22</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmers</i>	11. BIRTHPLACE (City and state or country) <i>Hardin Co. Tenn</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	

13a. FATHER'S NAME <i>John B. Donaldson</i>		13b. MOTHER'S MAIDEN NAME <i>Margery Sellars</i>		14. NAME OF HUSBAND OR WIFE <i>Walter Donaldson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT Address: <i>Mr. Walter Donaldson, Steele, Mo.</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Osteogenic Sarcoma of Lung + Bone (Tentative)</i>			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)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>1969</i>			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. 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 *11/57* to *2/16/59* and last saw her alive on *2/16/59*.  
Death occurred at *4:25 P* on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (D. or or title) *Cecil E. Halcomb, M.D.* 22b. ADDRESS *Steele, Mo.* 22c. DATE SIGNED *2/19/59*

23a. BURIAL, CREMATION, REMOVAL (Specify) *Removal* 23b. DATE *2-19-59* 23c. NAME OF CEMETERY OR CREMATORY *Green* 23d. LOCATION (City, town, or country) (State) *Steele, Mo*

24. FUNERAL DIRECTOR *Wm. J. ...* ADDRESS *Steele, Mo* 25. DATE RECD. BY LOCAL REG. *3-2-59* 26. REGISTRAR'S SIGNATURE *[Signature]*

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

PHYSICIAN COUNTY HEALTH DEPARTMENT  
COURTHOUSE PHONE 79  
CARUTHERSVILLE, MO.

MAR 4 1969

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 *Noel Dean* .....

Licensed Embalmer No. 3941  
P. O. Address Caruthersville

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.