

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010006
STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. _____ Registrar's No. 418

1. PLACE OF DEATH
a. COUNTY Laclede
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Spring Hollow TS Inside Limits Yes No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Brice Route Length of stay in 1b 50 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Laclede
c. CITY OR TOWN Lebanon 6530 Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) Brice Rt. Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last
(Type or print) Dollie J. J. Cheak

4. DATE OF DEATH Month Day Year
March 18, 1959

5. SEX Female **6. COLOR OR RACE** White **7. MARRIED** NEVER MARRIED WIDOWED **2** DIVORCED

8. DATE OF BIRTH Oct. 7, 1874 **9. AGE** (In years last birthday) 84 **10. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) at home **11. BIRTHPLACE** (City and state or country) Dallas County, Mo. **12. CITIZEN OF WHAT COUNTRY?** USA

13a. FATHER'S NAME John Berry **13b. MOTHER'S MAIDEN NAME** Sadie Chastain **14. NAME OF HUSBAND OR WIFE** C. C. Cheak

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.** None **17. INFORMANT** Mrs. J. S. Loudermilk, Lebanon, 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) Cerebral hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) arteriosclerosis
DUE TO (c) 331X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____

19. WAS AUTOPSY PERFORMED? YES NO 2

20a. ACCIDENT **SUICIDE** **HOMICIDE** **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. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK **NOT WHILE AT WORK** **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 3-8-59 to 3-18-59 and last saw her alive on 3-12-59
Death occurred at 3:20 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) B B Hurst, M.D. **22b. ADDRESS** Lebanon, Mo. **22c. DATE SIGNED** 3-20-59

23a. BURIAL, CREMATION, or other disposal (Specify) Burial **23b. DATE** 3/21/59 **23c. NAME OF CEMETERY OR CREMATORY** Flat Woods Cem. **23d. LOCATION** (City, town, or county) Laclede County, Mo. (State) _____

24. FUNERAL DIRECTOR S. P. Palmer ADDRESS Lebanon Mo **25. DATE RECD. BY LOCAL REG.** 3-21-1959 **26. REGISTRAR'S SIGNATURE** Hella L. Hays

(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.

1956 APR 8

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 S. R. Palmer

Licensed Embalmer No. 2208

P. O. Address La Grange

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.