

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS JUL 27 1959

59-024034

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 141

STATE FILE NUMBER 1

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Audrain</u>   |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Audrain</u> |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico</u>   |  | Length of stay in <u>10</u> da  |   | c. CITY OR TOWN <u>Centralia</u>  |  | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Audrain County</u>   |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   | d. STREET ADDRESS <u>RFD 4</u>  |  | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br><u>Lela McIntire</u>   |  |   | 4. DATE OF DEATH<br><u>July 16 1959</u> |   |  | Month Day Year   |  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>Caucasian</u>      | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH <u>7/7/96</u>  | 9. AGE (last birthday) <u>63</u>   | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>9</u> Hours <u></u> Min. <u></u>        | IF UNDER 24 HR<br>Hours <u></u> Min. <u></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>Audrain County, Mo.</u>  |  | 12. CITIZEN OF WHAT COUNTRY <u>USA</u>   |  |
| 13a. FATHER'S NAME <u>Robert L. Davis</u>   |  | 13b. MOTHER'S MAIDEN NAME <u>Annie Lander</u>   |   | 14. NAME OF HUSBAND OR WIFE <u>James Y. McIntire</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>No</u>   |   | 17. INFORMANT <u>James Y. McIntire</u> Address  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Cancer</u><br>DUE TO (b) <u>Primary Breast Cancer</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |  |   |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |
| 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<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____   |  |   |   |   |  |  |  |
| 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>7/6/59</u> to <u>7/15/59</u> and last saw <u>him</u> alive on <u>7/15/59</u><br>Death occurred at <u>3:15 a.m.</u> <u>7/16/59</u> m on the date stated above, and to the best of my knowledge, from the causes stated.  |  |   |   |   |  |  |  |
| 22a. SIGNATURE <u>Sue D. Codes M.D.</u> (Degree or title)   |  |   |   | 22b. ADDRESS <u>113 East Monroe, Mexico</u>   |  | 22c. DATE SIGNED <u>7/16/59</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE <u>7/17/59</u>               | 23c. NAME OF CEMETERY OR CREMATORY <u>City of Centralia</u>   |   | 23d. LOCATION (City, town, or county) <u>Centralia, Mo.</u>   |  | (State)  |  |
| 24. FUNERAL DIRECTOR <u>Pice De Meador Centralia, Missouri</u> ADDRESS  |  |   |   | 25. DATE RECD. BY LOCAL REG. <u>July 16 - 1959</u>  |  | 26. REGISTRAR'S SIGNATURE <u>Blanche Neely</u>                                     |  |

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

JUL 27 1959

OCT 1 1964

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Bill J. Meadows*

Licensed Embalmer No. 4876

P. O. Address Centralia, Mo

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.