

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025761

FILED VS JUL 28 1959

Registration District No. _____ Primary Registration District No. 3033 Registrar's No. 108

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Leclade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Leclade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u>		Length of stay in 1b <u>1 year</u>	c. CITY OR TOWN <u>Lebanon</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Louise G. Wallace</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>449 Center St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>Marguerite</u> Last <u>Doll</u>			4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-6-1884</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>house keeper</u>		11. BIRTHPLACE (City and state or country) <u>Plato, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Adam Doll</u>		13b. MOTHER'S MAIDEN NAME <u>Francis Scott</u>		14. NAME OF HUSBAND OR WIFE <u>none</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>Louise G. Wallace Hospital, Lebanon, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary Sclerosis</u>		<u>2 Mos.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive card. o vascular Disease</u>	<u>2 years</u>
DUE TO (c)		

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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.)
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20c. TIME OF INJURY -Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 _____
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21. I attended the deceased from 4/6/58 to 7/20/59 and last saw her per alive on 7/20/59
Death occurred at 12 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>George E. Fisher M.D</u>	(Degree or title)	22b. ADDRESS <u>Lebanon, Mo</u>	22c. DATE SIGNED <u>7/21/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>7-23-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pisgah</u>	23d. LOCATION (City, town, or county) <u>Texas County Missouri</u>
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24. FUNERAL DIRECTOR <u>A. J. Stahl</u>	ADDRESS <u>Lebanon, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7-23-1959</u>	26. REGISTRAR'S SIGNATURE <u>Hella L. Way</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *R. W. Barber*

Licensed Embalmer No. 3848

P. O. Address Mt. Home

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.