

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-031849

STATE FILE NUMBER

38 Primary Registration District No. 3006 Registrar's No. 578

AMENDED

Registration District No. **FILED OCT 2 1961**

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Howard	
b. CITY (If outside corporate limits, give TOWNSHIP only) Columbia		Length of stay in 1b 32 days	c. CITY OR TOWN Fayette Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Ellis Fischel State Cancer		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 202 Louisiana Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Florence Middle Louise Last Cason			4. DATE OF DEATH Month September Day 25 Year 1961			
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-26-96	9. AGE (last birthday) 65	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) Laundry at Lee Hospital		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and state or country) Cooper Co. Missouri	12. CITIZEN OF WHAT COUNTRY American	
13a. FATHER'S NAME Sid McDowell		13b. MOTHER'S MAIDEN NAME Jane Steward		14. NAME OF HUSBAND OR WIFE Widowed		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown	16. SOCIAL SECURITY NO. unknown	17. INFORMANT Hospital Records-Columbia, Missouri Address
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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 lyg (?)
IMMEDIATE CAUSE (a) Cancer of the transverse colon and (b) Cancer of the endometrium		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Abdominal abscess		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. 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 Boonville	COUNTY _____ STATE _____
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21. I attended the deceased from **8/23/61** to **sep 25 61** and last saw her alive on **sep 25 1961**
Death occurred at **8.50** A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature] (Degree or title) M.D.	22b. ADDRESS E. F. Cason Hosp. Columbia, Mo	22c. DATE SIGNED 9-25-61
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	23b. DATE 9-28-61	23c. NAME OF CEMETERY OR CREMATORY City Cemetery	23d. LOCATION (City, town, or county) Boonville Mo
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24. FUNERAL DIRECTOR Ralph A. Carr	ADDRESS Fayette Mo	25. DATE RECD. BY LOCAL REG. Sept 25, 1961	26. REGISTRAR'S SIGNATURE Mrs R E Palmer
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

OCT 4 1967

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,

~~by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William E. Furse

Licensed Embalmer No. 4870

P. O. Address Fayette, 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.