

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-035365

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 459

STATE FILE NUMBER

FILED OCT 10 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ
Rev. 4/59								
1 0168								
2 0090								
3								
4 1								
5 2								
6								
7 1								
8 0								
9 170X								
10								
11								
12 3-0								
13 10								

1. PLACE OF DEATH a. COUNTY <u>CAPE GIRARDEAU</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>BOLLINGER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP OR TOWN) <u>CAPE GIRARDEAU</u> Length of stay in 1b <u>3 weeks</u>		c. CITY OR TOWN <u>MARQUAND</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Southeast Mo. Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Route 1</u> Residence on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>ETTA</u> Last <u>STEELE</u>			4. DATE OF DEATH Month <u>OCT.</u> Day <u>6</u> Year <u>1963</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-1892</u>
9. AGE (last birthday) <u>71 yrs</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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>Burke Co., North Carolina</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>John W. Smith</u>	
13b. MOTHER'S MAIDEN NAME <u>Amanda Hildebrand</u>		14. NAME OF HUSBAND OR WIFE <u>Henry F. Steele</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>William A. Steele</u>		Address <u>8812 Tyrell Dr. St. Louis 36, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic Cancer</u> DUE TO (b) <u>Cancer of Breast</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u>
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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input 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.)	
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 _____ COUNTY _____ STATE _____
21. I attended the deceased from <u>11-8-61</u> to <u>10-6-63</u> and last saw ^{her} him alive on <u>10-6-63</u> . Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Charles Jones</u> (Degree or title) <u>1:45 AM</u>		22b. ADDRESS <u>Cape Girardeau, Mo.</u>	22c. DATE SIGNED <u>10-8-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>10-8-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Liberty Methodist Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Bollinger Co. Missouri</u>
24. FUNERAL DIRECTOR <u>SAM NAJIM, JR., FREDERICKTOWN, MO</u> ADDRESS _____		25. DATE RCD. BY LOCAL REG. <u>Oct. 9-63</u>	26. REGISTRAR'S SIGNATURE <u>Jesse Kasten</u>

USE BLACK INK OR TYPEWRITER RIBBON

OCT 17 1963

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 Robert P. Seabaugh, Student Embalmer No. 702

working under my personal supervision.

Student Robert P. Seabaugh
Signature of Student Embalmer

Signed Sam Sayin, Jr.

Licensed Embalmer No. 4299

P. O. Address Fredericktown, 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.