

FILED DEC 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38284**

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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

| | | | | | | | | | |
|--|--|---|--|--|-----------------------|--|---|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. 278 | | PRIMARY REG. DIST. NO. 3054 | | Registrar's No. 105 | | | |
| 1. PLACE OF DEATH a. COUNTY Pike | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Pike | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give town or town Louisiana) | | c. LENGTH OF STAY (in this place) 5 months | | c. CITY (If outside corporate limits, write RURAL and give township) Louisiana | | d. STREET ADDRESS (If rural, give location) 608 North Third St. | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Pike Co. Hospital | | | | d. STREET ADDRESS (If rural, give location) 608 North Third St. | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) SALLYE | | | b. (Middle) B | | c. (Last) PAGE | | 4. DATE OF DEATH (Month) (Day) (Year) NOV. 30, 1949 | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced | | 8. DATE OF BIRTH March 9, 1868 | | 9. AGE (In years last birthday) 81 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse | | 10b. KIND OF BUSINESS OR INDUSTRY Retired Nurse | | 11. BIRTHPLACE (State or foreign country) Kentucky | | 12. CITIZEN OF WHAT COUNTRY? U. S. | | IF UNDER 1 YEAR: Months 8 Days 21 Hours Min. | |
| 13a. FATHER'S NAME Robert Green McLeod | | | 13b. MOTHER'S MAIDEN NAME Jane Thomas | | | 14. NAME OF HUSBAND OR WIFE Edward Page | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Oren K. Campbell--Bloomington, Ill. | | | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Cervix with | | | | ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | 1 1/2 yrs | |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | | | DUE TO (b) generalized metastasis | | | | 6 mo. | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | | 171X | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | | | |
| 22. I hereby certify that I attended the deceased from 1948 to 11-30, 1949 , that I last saw the deceased alive on 11-29, 1949 , and that death occurred at 5:15 a. m. , from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE Chas. H. Lewellen M.D. (Degree or title) | | | | 23b. ADDRESS Louisiana, Missouri | | 23c. DATE SIGNED 11-30-49 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 12/1/49 | | 24c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery | | 24d. LOCATION (City, town, or county) (State) Louisiana, Missouri | | | |
| DATE REC'D BY LOCAL REG. Nov 30, 1949 | | REGISTRAR'S SIGNATURE Bernice Collier | | 25. FUNERAL DIRECTOR'S SIGNATURE 374 | | ADDRESS Sterne Funeral Home--Louisiana, MO. | | | |

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RECEIVED DEC 12 1940
 District Health Officer No. 10
 District File Number *12-49-20*
 Date Filed

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
 Student Embalmer

Signed *Virginia M. Sterne*

Licensed Embalmer No. *4645*

P. O. Address *Louisiana, 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 this body is not embalmed, fact should be so stated above.

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