

FILED FEB 27 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4058**

BIRTH NO. _____ REG. DIST. NO. **46** PRIMARY REG. DIST. NO. **4063** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Caldwell		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before and after). a. STATE Missouri b. COUNTY Caldwell	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hamilton		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hamilton	
c. LENGTH OF STAY (In this place) 3 yrs		d. STREET ADDRESS (If rural, give location) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home of Ernest M. Cubbin			

3. NAME OF DECEASED (Type or Print) a. (First) Margaret b. (Middle) M. Cubbin c. (Last) McCubbin		4. DATE OF DEATH (Month) (Day) (Year) Jan 31 1950	
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec 22 1877	9. AGE (In years last birthday) 72 Months 1 Days 9 Hours 0 Min. 0	
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10a. USUAL OCCUPATION (Give kind of work including most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Household	11. BIRTHPLACE (State or foreign country) Mooreville Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13. FATHER'S NAME Thomas Wright	13a. MOTHER'S MAIDEN NAME Della unknown	14. NAME OF HUSBAND OR WIFE Leroy M. Cubbin
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Year or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Ernest M. Cubbin ADDRESS Hamilton Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 17 DX
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic carcinoma		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Malignancy of breast DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR _____
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22. I hereby certify that I attended the deceased from **Jan 28**, 19**50**, to **JAN 30**, 19**50**, that I last saw the deceased alive on **JAN 30**, 19**50**, and that death occurred at **8:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE H. K. Elder (Degree or title) _____	23b. ADDRESS Hamilton Mo	23c. DATE SIGNED Feb 1 1950
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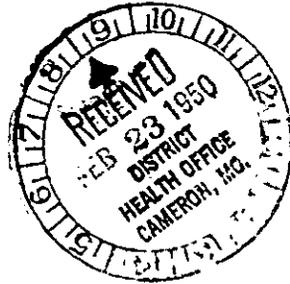
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan 31 1950	24c. NAME OF CEMETERY OR CREMATORY Kirkland Cem	24d. LOCATION (City, town, or county) (State) Hamilton Mo
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DATE REC'D BY LOCAL REG. Feb 1 1950	REGISTRAR'S SIGNATURE Gladys Jones 37	25. FUNERAL DIRECTOR'S SIGNATURE W. G. Jones ADDRESS Hamilton Mo
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

1130

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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.

Signed *R. J. Brown*

Signed.....
Student Embalmer

Licensed Embalmer No. 2052

P. O. Address *James Street*

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.