

FILED AUG 29 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26719

BIRTH NO. _____		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>3025</u>		Registrar's No. <u>36</u>		
1. PLACE OF DEATH a. COUNTY <u>Newage 0460</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Daveell</u>				
b. CITY OR TOWN <u>West Plains</u>		c. LENGTH OF STAY (in this place) <u>4 hrs</u>		c. CITY OR TOWN <u>West Plains #461</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <input checked="" type="checkbox"/>				d. STREET ADDRESS (If rural, give location) <u>South Hill 0</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>M. Elizabeth</u> b. (Middle) <u>Cage</u> c. (Last) <u>Cage</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>7-27-51</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>		8. DATE OF BIRTH <u>?</u>		
9. AGE (In years last birthday) <u>84</u>		10. MONTHS <u></u>		11. DAYS <u></u>		12. HOURS <u></u> MIN. <u></u>		
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 <input checked="" type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <u>Dent Co., Mo?</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Carroll Edwin</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Edwin</u>		14. NAME OF HUSBAND OR WIFE <u>Wilson Cage</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>			16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT'S SIGNATURE OR NAME <u>Bella Roberts West Plains</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cordiac Asthma</u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs.</u>	
			ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 <u>4/342</u>					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) _____ m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <u>July 27, 1951</u> to <u>July 27, 1951</u> , that I last saw the deceased alive on <u>July 27, 1951</u> , and that death occurred at <u>1:00</u> m., from the causes and on the date stated above.								
23a. SIGNATURE <u>Edwin A. W.D.</u> (Degree or title)				23b. ADDRESS <u>West Plains, Mo</u>		23c. DATE SIGNED <u>AUG 16 1951</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>NO</u>		24b. DATE <u>7-27-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Dalem MO</u>		24d. LOCATION (City, town, or county) (State) _____		
DATE REC'D BY LOCAL REG. <u>8-27-51</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u> <u>379</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Roberts West Plains Mo</u> ADDRESS _____				

(Licensed Embalmer's Statement on Reverse Side)

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

1010 E 903

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.....

Licensed Embalmer No.....

P. O. Address.....

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.