

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31227**

No. 300
10-48

SEP 30 1952

0361

BIRTH NO. _____ REG. DIST. NO. 114 PRIMARY REG. DIST. NO. 4184 Registrar's No. 571

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sullivan Mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sullivan Mo.</u>	
c. LENGTH OF STAY (In this place) <u>Life</u>		d. STREET ADDRESS (If rural, give location) <u>Sullivan Mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>North Side Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Mildred</u> b. (Middle) <u>Lucille</u> c. (Last) <u>Beals</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 24, 1952</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced 3</u>	8. DATE OF BIRTH <u>June 4, 1916</u>	9. AGE (In years) (last birthday) <u>36</u>	IF UNDER 1 YEAR (Days) <u>3</u>	IF UNDER 24 HRS. (Mins.) <u>20</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Crawford Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
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13a. FATHER'S NAME <u>John W. Carter</u>		13b. MOTHER'S MAIDEN NAME <u>Minnie Campbell</u>		14. NAME OF HUSBAND OR WIFE <u>Divorced</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Minnie Carter Bourbon Mo.</u> ADDRESS <u>R.F.D.</u>	
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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	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Cervix</u>		DUE TO (b) _____				6 mos.	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>Generalized metastasis</u>				<u>metast</u>	

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) <u>171X</u>	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT 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 July 2, 1952, to Sept 24, 1952, that I last saw the deceased alive on Sept 23, 1952, and that death occurred at 1:30 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>S. F. Ambrose M.D.</u>		23b. ADDRESS <u>Sullivan Mo.</u>		23c. DATE SIGNED <u>9/25/52</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>1</u>		24b. DATE <u>9-27-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>New Rock</u>		24d. LOCATION (City, town, or county) (State) <u>Crawford Co Mo</u>	
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DATE REC'D BY LOCAL REG. <u>9-26-52</u>		REGISTRAR'S SIGNATURE <u>C. A. Prantas 970</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thos. P. Shotton</u> ADDRESS <u>Sullivan Mo</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Pho. P. Shaffer*

Licensed Embalmer No. *2692*

P. O. Address *Sullivan 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.