

FILED JUN 6 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16368

State File No.

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 305K Registrar's No. 123

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Missouri</u> b. CITY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Charles</u>		c. CITY OR TOWN <u>Cuba</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>5 days</u>		e. STREET ADDRESS (If rural, give location) <u>02801</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>			

3. NAME OF DECEASED (Type or Print) <u>CECILIA</u>	a. (First)	b. (Middle)	c. (Last) <u>WHITE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May 18 1955</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>Single, Never Married</u>	8. DATE OF BIRTH <u>3-28-1874</u>	9. AGE (In years of last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>20</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>CARROLL, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Robert J. White</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Kaye Taylor</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Therese Adams</u>	ADDRESS <u>60304 St. Arthur Dr. St. Louis, Mo.</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, asthenia, 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 rectum</u>		<u>? 1 yr.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Pulmonary metastases</u> DUE TO (c) <u>bilateral</u>		<u>3 mos?</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>154X</u>			

19a. DATE OF OPERATION <u>5-18-1955</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of rectum</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 May 13, 1955, to May 18, 1955 that I last saw the deceased alive on May 18, 1955, and that death occurred at 9:40 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Russell Glider</u> (Degree or title)	23b. ADDRESS <u>St Charles Mo</u>	23c. DATE SIGNED <u>May 18 1955</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>5-21-1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem</u>	24d. LOCATION (City, town, or county) (State) <u>Cuba Mo</u>
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DATE REC'D BY LOCAL REG. <u>May 31 1955</u>	REGISTRAR'S SIGNATURE <u>Fannie Davidson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>F. D. A. Hamilton</u>	ADDRESS <u>Cuba Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 34

P. O. Address C. B. A. M.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.