

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29623

State File No. \_\_\_\_\_

FILED OCT 3-1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 3551 Registrar's No. 81

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, write RURAL and give town(ship)) <u>Brandenburg</u>		c. CITY OR TOWN <u>Brandenburg</u>	
c. LENGTH OF STAY (in this place) <u>4 days</u>		d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <input checked="" type="checkbox"/>		e. STREET ADDRESS (If rural, give location) <u>0400</u>	

3. NAME OF DECEASED (First) (Middle) (Last) <u>Lucy Ellen Upshaw</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9-18-1955</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>1-15-1884</u>		9. AGE (In years last birthday) <u>71</u> Months <u>8</u> Days <u>3</u> Hours <u>2</u> Min.

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 (City and State or Foreign Country) <u>Lora, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Wm. Nagan</u>			13b. MOTHER'S MAIDEN NAME <u>Eloise Elcorn</u>			14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>	

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>Dr. Matthew Easton</u>		ADDRESS <u>Keokuk, 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CARCINOMA, UTERUS OR BOWEL</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 months</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) <u>1992</u>					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>PARKINSON'S DISEASES</u>				<u>8-10 YEARS</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) _____	
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 JUNE 7, 1954 to SEPT 18, 1955 that I last saw the deceased alive on 9-3, 1955, and that death occurred at 7:28 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Jack N. Wilson, M.D.</u>		23b. ADDRESS <u>West Plains, Mo</u>		23c. DATE SIGNED <u>9-21-55</u>	
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24a. BURIAL CREMATION, REMOVAL (Specify) <u>10</u>		24b. DATE <u>9-22-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Howell Valley Methodist</u>		24d. LOCATION (City, town, or county) (State) <u>Mo</u>	
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DATE RECD BY LOCAL REG. <u>9-27-55</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Robertson</u>		ADDRESS <u>West Plains, 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.....  
Signature of Student Embalmer

Signed.....  
*J. L. Roberts*

Licensed Embalmer No. *347*

P. O. Address *Seattle*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.