

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40541

STATE FILE NUMBER

FILED DEC 31 1956

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 416

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY BOONE	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN COLUMBIA	a. STATE MISSOURI	b. COUNTY FRANKLIN
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ELLIS FISCHER CARE CENTER		c. CITY OR TOWN SULLIVAN	d. STREET ADDRESS #6 E. WASHINGTON
Length of stay in 1b 26 DAYS		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First JOSEPHINE	Middle LOUISE	Last COUDLE	Month 12	Day 26	Year 1956
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-21-1917	9. AGE (In years last birthday) 39	IF UNDER 1 YEAR Months 2 Days 5 Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) St Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul Spindler			14. MOTHER'S MAIDEN NAME Louise Lamm		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ✓	17. INFORMANT HOSPITAL RECORDS		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pneumonitis following operation			INTERVAL BETWEEN ONSET AND DEATH 1 day
DUE TO (b) Recurrent epidermoid carcinoma of uterine cervix.			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY a. m. Hour p. m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from **4-16-51** to **12-26-56** and last saw her alive on **12-26-56**
Death occurred at **2:00 A.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Richard E. Johnson, M.D.	22b. ADDRESS Columbia, Mo	22c. DATE SIGNED 12-26-56
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-28-56	23c. NAME OF CEMETERY OR CREMATORY 1007 Sullivan	23d. LOCATION (City, town, or county) (State) Sullivan Mo
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24. FUNERAL DIRECTOR Shaffer Funeral Home	ADDRESS Sullivan Mo	25. DATE RECD. BY LOCAL REG. DEC 26 1956	26. REGISTRAR'S SIGNATURE Mr R.E. Palmer
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(Licensed Embolmer's Statement on Reverse Side)

00-56
diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

APR 17 1957

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 *Thor P. Shaffer*

Licensed Embalmer No. *2.6*

P. O. Address *Sullivan*

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