

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3703

FILED MAR 4 1957

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 66

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>BOONE</u>		a. STATE <u>MISSOURI</u> b. COUNTY <u>BUCHANAN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>COLUMBIA</u>		c. CITY OR TOWN <u>St JOSEPH</u> ⁰¹¹⁸ ₀	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ELLIS FISCHER ST. CL</u>		d. STREET ADDRESS (If outside, give location) <u>1018 OLIVE ST.</u>	
Length of stay in lb <u>30 DAYS</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <u>SINA</u> Middle <u>JANE</u> Last <u>MCVEY</u>		Month <u>2</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-20-1878</u>
9. AGE (In years last birthday) <u>78</u>		10. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (City and state or country) <u>ANDREW Co. MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALLEN LANCE</u>		14. MOTHER'S MAIDEN NAME <u>ROSIE VOLLENBECK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis, acute</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 da.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Disruption uretero-ileal anastomosis</u>			
DUE TO (c) <u>Postoperative ischemia + necrosis ureters</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<u>Carcinoma urethra, post operative</u> <u>181X</u>			
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.) <u>7</u>		
20c. TIME OF INJURY Hour <u>—</u> Month <u>—</u> Day <u>—</u> Year <u>—</u> a. m. <u>—</u> p. m. <u>—</u>			
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 <u>Jan. 29 1957</u> to <u>Feb 27</u> and last saw <u>her</u> alive on <u>—</u>			
Death occurred at <u>Feb 27 1:20 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Patrick W. Foster MD</u>	22b. ADDRESS <u>EFS Cancer Hosp.</u>	22c. DATE SIGNED <u>2-28-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/2/1956</u>	23c. NAME OF CEMETERY OR CREMATORY <u>West Lawn</u>	23d. LOCATION (City, town, or county) (State) <u>De Kalb, Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Lynnard Spunkle, Columbia, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Mar. 1 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmore</u>	

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

(Licensed Embalmer's Statement on Reverse Side)

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, ~~by~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Lymon H. Sprinkle*

Licensed Embalmer No. *401*

P. O. Address *Columbia*

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.