

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **2913**

FILED APR 8 - 1957

Registration District No. **53** Primary Registration District No. **3009** Registrar's No. **204**

1. PLACE OF DEATH a. COUNTY <b>Cape Girardeau</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Cape Gir.</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Jackson</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Jackson</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>606 N Georgia</b>			Length of stay in lb <b>Several yrs</b>		d. STREET ADDRESS <b>606 N. Georgia</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>L.</b> Last <b>Penny</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>25</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 18, 1868</b>	9. AGE (In years last birthday) <b>89</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housekeeping</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Daisy Mo.</b>	
13. FATHER'S NAME <b>Calvin Drum</b>			14. MOTHER'S MAIDEN NAME <b>Hannah Fulbright</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. J. H. Bowers</b> Address <b>Jackson, Mo.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the breast</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>170X</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Hour _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT <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 <b>Feb. 25, 1957</b> to <b>Feb. 25, 1957</b> and last saw her <b>alive on Feb. 25, 1957</b> Death occurred at <b>5:00 P. m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>E. F. McDonald M.D.</b> (Degree or title)			22b. ADDRESS <b>Jackson, Mo.</b>		22c. DATE SIGNED <b>3-6-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb. 27, 1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Salem</b>	
				23d. LOCATION (City, town, or county) (State) <b>Daisy Mo.</b>	
24. FUNERAL DIRECTOR <b>S. C. Crisraft</b> ADDRESS <b>Jackson, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>4-2-1957</b>		26. REGISTRAR'S SIGNATURE <b>C. C. Summers</b>	

health, Welfare public service  
 000-56  
 Director, coroner, etc. must use only standard maintenance forms. Do not use symptoms when not treated. All diseases in Part I must be casually related. Chroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 1-0

STATEMENT BY LICENSED EMBALMER.

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em  
by me, or by ..... Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Gene C. Cawcett*

Licensed Embalmer No. *43*

P. O. Address *Jackson*

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.