

Health,
& Welfare
S. Public
th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12355
STATE FILE NUMBER

FILED MAY 14 1957

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 117

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY CALLAWAY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY SCOTT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FULTON		c. CITY OR TOWN SIKESTON	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION STATE HOSPITAL #1		d. STREET ADDRESS (If outside, give location) 327 LUTHER STREET	
Length of stay in lb 3 1/2 YRS.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last LULA WHITE			4. DATE OF DEATH Month Day Year MAY 9, 1957		
------------------------------------------------------------------------	--	--	---------------------------------------------------	--	--

5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1897	9. AGE (In years lost birthday) 59		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
------------------	---------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------	---------------------------------------	--	-------------------------------------------	------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC SERVANT	10b. KIND OF BUSINESS OR INDUSTRY SAME	11. BIRTHPLACE (City and state or country) LOUISIANA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
-----------------------------------------------------------------------------------------------------------------	-------------------------------------------	---------------------------------------------------------	----------------------------------------

13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE NONE
-------------------------------	--------------------------------------	-------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If "no" give war or dates of service) NO	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address STATE HOSPITAL #1, FULTON, MISSOURI
--------------------------------------------------------------------------------------------------------------------	------------------------------------	--------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC DECOMPENSATION		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) BRONCHOPNEUMONIA	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 491X		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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STATE HOSPITAL #1	20f. CITY, TOWN, OR LOCATION COUNTY STATE
------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------	-------------------------------------------

21. X attended the deceased from 1-7-54 to 5-9-57 Death occurred at 10:15 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.	XXXXXXXXXXXXXXXXXXXXXXXXXXXX him
----------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------

22a. SIGNATURE (Degree or title) T.D.MC CARTHY, M.D. <i>Thomas D. McCarthy, M.D.</i>	22b. ADDRESS STATE HOSPITAL #2, FULTON, MO.	22c. DATE SIGNED 5-9-57
-----------------------------------------------------------------------------------------	------------------------------------------------	----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 5/10/57	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) Columbia Mo.
------------------------------------------------------	----------------------	--------------------------------------------------------	---------------------------------------------------------------

24. FUNERAL DIRECTOR <i>Robert D. Johnston</i>	ADDRESS Columbia Mo.	25. DATE RECD. BY LOCAL REG. May-10-1957	26. REGISTRAR'S SIGNATURE <i>Martha Lawrence</i>
---------------------------------------------------	-------------------------	---------------------------------------------	-----------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

securing the medical certification in the specific manner required by 1952-1953 laws. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

426

LSE 27 AM

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.....

P. O. Address.....

**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.**