

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUL 23 1957

Registration District No. 264 Primary Registration District No. 589 STATE FILE NUMBER  
Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Ozark</u>		2. USUAL RESIDENCE (Where deceased lived. If in institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ozark</u>	
b. CITY OR TOWN <u>Dora, Mo</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Dora Mo</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <input checked="" type="checkbox"/> 0176	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ada Canady Cash</u>		4. DATE OF DEATH Month Day Year <u>7-9-57</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 type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-1897</u>
9. AGE (In years last birthday) <u>60</u>		10. IF UNDER 24 HRS. Months <u>6</u> Days <u>8</u> Hours <u></u> Min. <u></u>	
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"/>	
11a. BIRTHPLACE (City and state or country) <u>Merced Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>W. J. Canady</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Norris R.E. Cash</u>	
14. NAME OF HUSBAND OR WIFE <u>R.E. Cash</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>	
16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>R.E. Cash, Dora, Mo.</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>Adenocarcinoma, Metastatic</u> DUE TO (b) <u>Adenocarcinoma, endometrium</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Carcinoma breast 1940 170x</u>			19. INTERVAL BETWEEN ONSET AND DEATH <u>1957</u> <u>1953</u>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>_____</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <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.) _____		20f. CITY, TOWN, OR LOCATION COUNTY STATE _____	
21. I attended the deceased from <u>Nov. 23 1956</u> and last saw her alive on <u>June 1957</u> Death occurred at <u>3:25 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Jack N. Wiley, M.D.</u>		22b. ADDRESS <u>West Plains, Mo</u>	
22c. DATE SIGNED <u>7-13-57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>NO</u>	
23b. DATE <u>7-12-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spiegelon</u>	
23d. LOCATION (City, town, or county) (State) <u>Dora Mo</u>		24. FUNERAL DIRECTOR <u>Kabernus, Matt</u> ADDRESS <u>Mo</u>	
25. DATE RECD. BY LOCAL REG. <u>7-23-57</u>		26. REGISTRAR'S SIGNATURE <u>Tom Dunderon, acting dir</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JUL 8 0 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

*H. S. Roberts*

Licensed Embalmer No. *343*

P. O. Address *West Va*

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.