

Health, Welfare
Public
Service

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ALL diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All symptoms must be stated. Do not use only standard abbreviations. Doctor, coroner, or other person who certifies to a death due to natural causes must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25850

STATE FILE NUMBER

FILED JUL 31 1957

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 233

1. PLACE OF DEATH a. COUNTY <u>ST. FRANCOIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. FRANCOIS</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>FARMINGTON</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 <u>Bonne Terre Hosp.</u>			Length of stay in 1b <u>5 hrs</u>		d. STREET ADDRESS <u>R R 1</u>		(If outside, give location) <u>948</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Lucinda</u> Last <u>Lee</u>				4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1957</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 4 1877</u>		9. AGE (In years last birthday) <u>79</u> IF UNDER 1 YEAR Months <u>11</u> Days <u>13</u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state or country) <u>Knob Wick, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John W. Webb</u>				14. MOTHER'S MAIDEN NAME <u>Lucinda Williams</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>370-20-780B</u>		17. INFORMANT <u>Anderson Lee, Farmington, 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>Arteriosclerotic heart disease</u> DUE TO (b) <u>Generalized arteriosclerosis</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>4260</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>5 yrs.</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.)						
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____									
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>May 3 1957</u> to <u>July 17, 1957</u> and last saw her alive on <u>7-7-57</u> Death occurred at <u>9:25 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>C. E. Caulter, M.D.</u>				22b. ADDRESS <u>Farmington Mo</u>			22c. DATE SIGNED <u>7-20-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-20-1957</u>	23c. NAME OF CEMETERY OR CREMATORY. <u>1,908 Cemetery</u>		23d. LOCATION (City, town, or county) <u>Knob Wick, Mo</u>		(State)		
24. FUNERAL DIRECTOR <u>Miller Funeral Home, Farmington, Mo</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>July 20, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</u>		

(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, or by _____, Student Embalmer No. _____ working under my personal supervision..

Student _____
Signature of Student Embalmer

Signed Paul Dugal
Licensed Embalmer No. 412
P. O. Address Farmington

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.