

Health, Welfare & Public Service

300
1-56

Secretary, coroner, etc., must use only standard nomenclature in Part 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.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31517

STATE FILE NUMBER

FILED OCT 7 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 910-A

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Laclede</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Eldridge 0539</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Hospital</u>			Length of stay in 1b <u>1 day</u>		d. STREET ADDRESS (If outside, give location) <u>Eldridge</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Carol</u> Middle <u>Webster</u> Last <u>Webster</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>18</u> Year <u>1957</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 13 - 1957</u>		9. AGE (In years last birthday) <u>1</u> <u>5</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>5</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Laclede Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Guy Webster</u>				14. MOTHER'S MAIDEN NAME <u>Nola (P)</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>—</u>		17. INFORMANT <u>Burge Hospital Record</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>Acidosis</u> DUE TO (b) <u>Gastro enteritis</u> DUE TO (c) <u>5710</u> 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>Interstitial pneumoniae</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 d ?</u> <u>3 wk</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 <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>9-17-57</u> to <u>9-18-57</u> and last saw her alive on <u>9-18-57</u> Death occurred at <u>2:15 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Mike Beeseck, MD</u>				22b. ADDRESS <u>Springfield Mo</u>		22c. DATE SIGNED <u>9-30-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Sept 20-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill Cemetery</u>		23d. LOCATION (City, town, or county) <u>Camden Co</u>		STATE <u>Mo</u>	
24. FUNERAL DIRECTOR <u>Reed Funeral Home</u> ADDRESS <u>Camden Mo</u>				25. DATE RECD. BY LOCAL REG. <u>10-3-57</u>		26. REGISTRAR'S SIGNATURE <u>Edith Williamson</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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

Robert W Reed

Licensed Embalmer No. *374*

P. O. Address *Camden*

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.