

FILED OCT 17 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36904
STATE FILE NUMBER

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 118

5. 300
ev. 1-5708

1. PLACE OF DEATH a. COUNTY <u>PIKE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>PIKE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>LOUISIANA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>FOLIA</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PIKE CO. HOSP</u>		Length of stay in 1b <u>3 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>FOLIA</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>VIRGINIA LEE DAWSON</u>			4. DATE OF DEATH Month Day Year <u>SEPT 30, 1957</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 26, 1864</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 <u>HOME</u>	9. AGE (In years, by birthday) <u>92</u>
11. BIRTHPLACE (City and state or country) <u>LINCOLN CO., MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>J. W. M. PALMETT</u>		13b. MOTHER'S MAIDEN NAME <u>ANNIE HARVEY</u>	14. NAME OF HUSBAND OR WIFE <u>—</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>NONE</u>	17. INFORMANT <u>Mrs Hilda Riggs, Folia, Mo.</u>
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>Cerebral vascular accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>
DUE TO (b) <u>Central Pneumonitis.</u>			<u>2 days;</u>
DUE TO (c) <u>Inter-trochanteric fracture of left hip. Fracture of left radius at distal end.</u>			<u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>9040 21</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>Patient fell</u>	
20c. TIME OF INJURY Hour a.m. Month, Day, Year <u>9-27-57</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <u>Fracture left radius at distal end Inter-trochanteric fracture left hip</u>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. CITY, TOWN, OR LOCATION <u>Folia</u>	COUNTY <u>Pike</u>
21. I attended the deceased from Death occurred at <u>9:45 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.		and last saw her alive on <u>9-30-57</u>	
21a. SIGNATURE <u>Clas A. Lavelle M.D.</u>		21b. ADDRESS <u>Louisiana, Mo.</u>	21c. DATE SIGNED <u>10/2/57</u>
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE <u>Oct 2, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FOLIA CEMETERY</u>
22d. LOCATION (City, town, or county) <u>FOLIA, MISSOURI</u>		22e. STATE <u>MISSOURI</u>	
24. FUNERAL DIRECTOR <u>GEO. M. COLLIER, LOUISIANA</u>		25. DATE RECD. BY LOCAL REG. <u>Oct 2, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Callier</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Missouri (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

Licensed Embalmer No. 3839

P. O. Address Louisiana

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.