

Health,  
& Welfare  
S. Public  
th Service

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v. 1-56

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. Coroner cannot certify to a death due to natural causes.

Securing the medical certification in the specific manner required by §§ 3, 140 works 1949.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED DEC 5 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39408

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 76

1. PLACE OF DEATH a. COUNTY <u>BUTLER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>WAYNE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>POPLAR BLUFF</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>SHOOK</u> 1110
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DOCTORS HOSPT.</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>LEANDER</u> Middle <u>R</u> Last <u>UNDERWOOD</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1957</u>		
5. SEX <u>MALE</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>OCT. 31, 1876</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM.</u>	11. BIRTHPLACE (City and state or country) <u>KIME, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN M. UNDERWOOD</u>			14. MOTHER'S MAIDEN NAME <u>HENRETTA HUGGENS</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. <input checked="" type="checkbox"/>	17. INFORMANT <u>LESLIE UNDERWOOD</u> Address <u>CLARKSVILLE 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>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUPLICATE (b) <u>Cancer of the urinary bladder</u>		<u>2 years</u>
	DUPLICATE (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>181X</u>		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.		
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 Feb 1957 to Nov 25 1957 and last saw <sup>her</sup> him alive on Nov 25 1957  
Death occurred at 1:10 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE T. E. Ruff (Degree or title) M.D. 22b. ADDRESS Knibbert Clinic Poplar Bluff Mo 22c. DATE SIGNED 11-27-57

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Nov. 27, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RICHMOND CHAPEL</u>	23d. LOCATION (City, town, or county) (State) <u>SHOOK Mo.</u>
24. FUNERAL DIRECTOR <u>High Funeral Home</u> By <u>M.E. Bowler</u>		25. DATE RECD. BY LOCAL REG. <u>12/29/57</u>	26. REGISTRAR'S SIGNATURE <u>G.A. Threlkeld</u>

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

DEC 2 1957

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

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 me, Student Embalmer No. \_\_\_\_\_, working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed Marvin E Bowles

Licensed Embalmer No. 44

P. O. Address Piedmont

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.