

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

248

STATE FILE NUMBER

FILED JAN 24 1958

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 40

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN Rushville	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hdspt.		d. STREET ADDRESS Route 2	
Length of stay in lb 3 days		Reside on Farm Yes ☒ No ☐	
3. NAME OF DECEASED (Type or print) First Middle Last Lula I Cabiness		4. DATE OF DEATH Month Day Year Jan. 11, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH Feb. 23, 1882
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. KIND OF BUSINESS OR INDUSTRY Own home	9c. AGE (In years last birthday) 75
10a. FATHER'S NAME Samuel G. West		10b. MOTHER'S MAIDEN NAME Panola Chittwood	
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		12. SOCIAL SECURITY NO. none	
13. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure		14. BIRTHPLACE (City and state or country) De Kalb, Mo.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive Heart Disease		15. CITIZEN OF WHAT COUNTRY? U. S. A.	
DUE TO (c) Essential Hypertension		16. NAME OF HUSBAND OR WIFE Edward F. Cabiness	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Toxic Goiter		17. ADDRESS Route 2 Nelson R. Cabiness Rushville, Mo.	
18. ACCIDENT SUICIDE HOMICIDE ☐ ☐ ☐		19. INTERVAL BETWEEN ONSET AND DEATH 3 days	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20d. INJURY OCCURRED WHILE AT ☐ NOT WHILE AT WORK ☐		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 Jan 8, 1958 to Jan 11, 1958 and last saw her alive on Jan 11, 1958		Death occurred at 12:10 p m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) Sharon E. Wagner M.D.		22b. ADDRESS 301 Illinois Ave St. Joseph, Missouri	
22c. DATE SIGNED 1/13/58		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE Jan. 13, 58		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	
23d. LOCATION (City, town, or county) Buchanan County, Mo.		24. FUNERAL DIRECTOR Clark Funeral Home	
25. DATE RECD. BY LOCAL REG. Jan 20, 1958		26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton	

(Licensed Embalmer's Statement on Reverse Side)

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

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 *Emil A. Clark*

Licensed Embalmer No. *4238*

P. O. Address *St. Joseph*

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.