

Health,  
& Welfare  
Public  
Service

S. 300  
v. 1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-004448

STATE FILE NUMBER

FILED FEB 17 1958

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 75

1. PLACE OF DEATH a. COUNTY <b>DOONE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>WAGNER</b>			
b. CITY OR TOWN <b>COLUMBIA</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>COMPETITION</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>U. of Mo. MED. CENTER</b>			Length of stay in lb <b>41 days</b>			d. STREET ADDRESS (If outside, give location) <b>RFD Lebanon, Mo.</b>	
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>CAUDLE</b> Last <b>CRISP</b>				4. DATE OF DEATH Month <b>FEB</b> Day <b>12</b> Year <b>'58</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-16-1893</b>		9. AGE (In years last birthday) <b>65</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>McComb, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>ELIAS CAUDLE</b>			13b. MOTHER'S MAIDEN NAME <b>BELLE JUBNER</b>		14. NAME OF HUSBAND OR WIFE <b>HENRY CRISP</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Henry Crisp - Same (Husband)</b> 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) <b>Peritonitis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Duodenal fistula</b>						<b>4 wks</b>	
DUE TO (c) <b>Post-operative repair duodeno-colic fistula</b>						<b>2 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <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 <b>1/2/58</b> to <b>2/12/58</b> and last to <b>live</b> on <b>2/12/58</b> Death occurred at <b>12:00 noon</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>William H. Wade M.D.</b>				22b. ADDRESS <b>U. of Mo. Hosp.</b>		22c. DATE SIGNED <b>2/12/58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>2-12-1958</b>	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State) <b>Lebanon, Mo.</b>	
24. FUNERAL DIRECTOR <b>Parker Funeral Service, Columbia, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>Feb 12 1958</b>		26. REGISTRAR'S SIGNATURE <b>Mrs R E Palmer</b>		

FEB 20 1958

FEB 28 1958

**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. 5010.....  
P. O. Address Columbia, Mo......

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.