

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-011981

STATE FILE NUMBER

2798

FILED MAR 24 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

Health,  
Welfare  
Public  
Service

300  
1-56

ALL diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>          </u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>CASEYVILLE 612</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>MISSOURI PACIFIC HOSPITAL</u>		Length of stay in 1b <u>40</u>	d. STREET ADDRESS (If outside, give location) <u>32 500 TWIN DRIVE</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>IVA</u> Middle <u>MAUDE</u> Last <u>MC QUEEN</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>9</u> Year <u>1958</u>		
5. SEX <u>FEMALE</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>December 27, 1895</u>	9. AGE (In years last birthday) <u>62</u> IF UNDER 1 YEAR: Months <u>          </u> Days <u>          </u> IF UNDER 24 HRS.: Hours <u>          </u> Min. <u>          </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		11. BIRTHPLACE (City and state or country) <u>CARROLLTON ARK.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>DANIEL NEWBERRY</u>			
14. MOTHER'S MAIDEN NAME <u>MAGGIE PIERCE</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>NO-VE</u>		17. INFORMANT Address <u>CASEYVILLE, ILL.</u> <u>CHAS. H. MC QUEEN</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>CEREBRO VASCULAR ACCIDENT.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>46.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Surgical shock</u>					
DUE TO (c) <u>Carcinoma of the cervix 171x</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>STATUS POSTINTESTINAL OBSTRUCTION K POST-PELVIC EXENTERATION.</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</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> 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>1/17/58</u> to <u>3/9/58</u> and last saw <sup>per</sup> him alive on <u>3/8/58</u> Death occurred at <u>MISSOURI PAC. HOSPITAL</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Barton Passanante, M.D.</u>			22b. ADDRESS <u>412 N. Taylor, St. Louis</u>		22c. DATE SIGNED <u>3/9/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>3-12-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VALHALLA CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BELLEVILLE, ILLINOIS</u>
24. FUNERAL DIRECTOR <u>CHAS. M. BURKE-E. ST. LOUIS, ILL.</u>		25. DATE RECD. BY LOCAL REG. <u>MAR 10 '58</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u> <u>S.P.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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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 *Chas Burke*.....

Licensed Embalmer No. *24*.....

P. O. Address *E. H. Lane*.....

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.