

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 diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-014754

STATE FILE NUMBER

FILED MAY 12 1958

Registration District No. 159 Primary Registration District No. 5591 Registrar's No. 16

0500

|  |  |   |  |   |  |  |   |  |  |
|--|--|---|--|---|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>JEFF.</u>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>JEFF.</u>                         |  |  |   |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>HILLSBORO CENTRAL</u>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>      |  | c. CITY OR TOWN <u>HILLSBORO</u>  |  | 0500<br>Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |  |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 Mi N. ON HY. 21</u>   |  |   | Length of stay in lb <u>48 YRS.</u>  |   | d. STREET ADDRESS <u>HY. 21 + Y</u>    |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>GRACE</u> Middle <u>MAE</u> Last <u>LANGFORD</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>APR.</u> Day <u>25</u> Year <u>1958</u>  |  |  |   |  |  |
| 5. SEX <u>F.</u>   |  | 6. COLOR OR RACE <u>W</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>NOV. 25 1909</u>  |   | 9. AGE (In years last birthday) <u>48</u><br>IF UNDER 1 YEAR<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>ASST. CASHIER</u>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>BANK</u>   |   |  | 11. BIRTHPLACE (City and state or country)<br><u>HILLSBORO, Mo</u>                           |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>LON WIBBLE</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>LOLA CAGE</u>  |  |  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |  |   | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><u>LEWIS LANGFORD</u> |  |   | Address<br><u>HILLSBORO</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Breast and uterus</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>1992 |  |   |  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>5-6 yrs</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<br>Hour _____<br>a. m. _____<br>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 <u>12-7-58</u> to <u>4-25-58</u> and last saw her <u>alive on 4-23-58</u><br>Death occurred at <u>1:50 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.  |  |   |  |   |  |  |   |  |  |
| 22a. SIGNATURE (Degree or title)<br><u>Thos E Feller MD</u>  |  |   |  | 22b. ADDRESS<br><u>DeSoto Mo</u>  |  |  |   | 22c. DATE SIGNED<br><u>4-28-58</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City, town, or county) (State)  |   |  |  |
| <u>BURIAL</u>  |  | <u>APR. 27, 58</u>  |  | <u>HILLSBORO</u>  |  | <u>HILLSBORO Mo.</u>   |   |  |  |
| 24. FUNERAL DIRECTOR<br><u>D. B. PIETRICH</u>  |  |   |  | ADDRESS<br><u>DeSoto Mo</u>   |  | 25. DATE RECD. BY LOCAL REG.<br><u>4-29-58</u>   |   | 26. EMBALMER'S SIGNATURE<br><u>Oliver Quarles, Jr</u>                                  |  |

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

JEFFERSON COUNTY HEALTH DEPT.  
HILLSBORO, MISSOURI

DATE RECEIVED

MAY 2 1959

VS  
MAY 11 1959

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 *J. B. Dietrich*

Licensed Embalmer No. *419*

P. O. Address *W. B. Dietrich*

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.