

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028210
STATE FILE NUMBER

FILED SEP 15 1958

Registration District No. 38 Primary Registration District No. 2006 Registrar's No. 408

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY Boone			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY Boone		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Columbia		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR UNIVERSITY OF MA INSTITUTION Medical Center		Length of stay in lb 134 Days	d. STREET ADDRESS 401 PARK		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First VIVIAN Middle Holt Last NORRIS			4. DATE OF DEATH Month 9 Day 12 Year 58		
5. SEX Female	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-25		9. AGE (In years last birthday) 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Sedalia, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME CARTER, William		13b. MOTHER'S MAIDEN NAME Venable, Mable		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 491-07-7446		17. INFORMANT Medical Records, University of Mo. 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) Probably Malnutrition + Electrolyte Imbalance 8/19/57 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Endometrial Carcinoma + Carcinomatosis to 9/12/58. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK <input type="checkbox"/> 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 8/19/57 to 9/12/58 and last saw her alive on 9/11/58 Death occurred at 4:30 AM 9/12/58 A. M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Dr. M. Williams, M.D.			22b. ADDRESS U. of Mo. Med Center Columbia, Mo.		22c. DATE SIGNED 9/12/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9/12/58	23c. NAME OF CEMETERY OR CREMATORY Removal		23d. LOCATION (City, town, or county) (State) Sedalia Mo
24. FUNERAL DIRECTOR Wm. R. ...		ADDRESS 401 W Cooper		25. DATE RECD. BY LOCAL REG. Sept 12 1958	26. REGISTRAR'S SIGNATURE Mrs R E Palmer

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

SEP 19 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 *Francis Alexander*

Licensed Embalmer No. *4245*
P. O. Address *San Jose, Cal.*

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.