

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028240

STATE FILE NUMBER

FILED SEP 2 1958 Registration District No. 38 Primary Registration District No. 5120 Registrar's No. 367

5. 300
1-57

| | | | | | |
|---|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Boone | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Boone | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia Township | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN Brown Station, Mo. | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Brown Station, Mo. | | Length of stay in lb Life | d. STREET ADDRESS (If outside, give location) ----- | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Carrie Mae McCauley | | | 4. DATE OF DEATH Month August Day 22 Year 1958 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 28, 1883 | 9. AGE (In years last birthday) 74 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (City and state or country) Boone County, Mo. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13a. FATHER'S NAME Jasper Phillips | | 13b. MOTHER'S MAIDEN NAME Ellen Singleton | | 14. NAME OF HUSBAND OR WIFE deceased Daniel B. McCauley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Address Mrs. A. G. Pierce Hallsville, Mo. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Decompensation | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 Month |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Senile Debility | | | | | |
| DUE TO (c) Emotion Malnutrition | | | | | 3 Yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4222 | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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. Month, Day, Year _____ | | | | | |
| 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 July 1955 to August 1958 and last saw her alive on July 17, 1958 Death occurred at 7:00 PM 8-22-58 A m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE Mattie Spraska DO (Degree or title) | | | 22b. ADDRESS Columbia Mo | | 22c. DATE SIGNED 8-22-58 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8-24-1958 | 23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery | | 23d. LOCATION (City, town, or county) (State) Boone County, Mo. |
| 24. FUNERAL DIRECTOR Lyman Sprinkle Columbia, Mo. | | | 25. DATE RECD. BY LOCAL REG. Aug 23 1958 | 26. REGISTRAR'S SIGNATURE Mrs R E Palmer | |

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

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 *Lynard H. Sprinkle*

Licensed Embalmer No. *4013*

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.