

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5468-58

58-028457

STATE FILE NUMBER

FILED SEP 9 1958

Registration District No. 53 Primary Registration District No. _____ Registrar's No. 446

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> COUNTY <u>Cape Girardeau</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>0164 Cape Girardeau</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>So E. Mo. Hosp</u> Length of stay in lb <u>8 hours</u> | | d. STREET ADDRESS (If outside, give location) <u>1635 Luce St</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle <u>Birk</u> Last <u>Leming</u> | | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>24</u> Year <u>1958</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 24 1958</u> |
| 9. AGE (In years last birthday) <u>0</u> MONTHS <u>0</u> DAYS <u>8</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | 11. BIRTHPLACE (City and state or country) <u>Cape Girardeau Mo</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13a. FATHER'S NAME <u>Charles L Leming</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Joyce M. Birk</u> | | 14. NAME OF HUSBAND OR WIFE <u>None</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT <u>Charles L Leming</u> Address <u>Cape Gir. Mo</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>A telecystitis due to</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Retinal Hemorrhage of brain, subdural hematoma - rt. occipital</u> DUE TO <u>Increased intracranial pressure</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>7600</u> |
| 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"/> |
| 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 checked="" 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>8/24/58</u> to <u>8/24/58</u> and last saw her alive on <u>8/24/58</u> Death occurred at <u>4:46 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Chas L. Herbert, M.D.</u> | | 22b. ADDRESS <u>Cape Girardeau, Mo</u> | 22c. DATE SIGNED <u>8/25/58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | 23b. DATE <u>Aug 23-1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u> | 23d. LOCATION (City, town, or country) (State) <u>Cape Girardeau, Mo</u> |
| 24. FUNERAL DIRECTOR <u>Walshers Funeral Home</u> | 25. DATE RECD. BY LOCAL REG. <u>Sept. 5, 1958</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs. Homer Cooper</u> | |

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Cape Girardeau Mo (Licensed Embalmer's Statement on Reverse Side)

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 *William Lee Thomas*

Licensed Embalmer No. *4410*

P. O. Address *Bay St. Andrews*

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.