

Health,  
& Welfare  
S. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-031984  
STATE FILE NUMBER

12548-58  
FILED SEP 22 1958

Registration District No. 53 Primary Registration District No. Registrar's No. 461

S. 300  
V. 1-57

1. PLACE OF DEATH a. COUNTY <u>Cape.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Cape</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>0160</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>Osteo pathic Hosp.</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>TERESA Louise MARGARBE</u>			4. DATE OF DEATH Month Day Year <u>Sept. 11 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>Sept. 10 1958</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) F UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (City and state or country) <u>Cape Girardeau Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Cape U.S.A.</u>

13a. FATHER'S NAME <u>Robert Henry MARGARBE.</u>		13b. MOTHER'S MAIDEN NAME <u>Dorothy J. Roll</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Robert Henry Margrave 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>Atelectasis - 1 day</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	<u>7620</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 Month, Day, Year a.m. p.m.			20d. INJURY OCCURRED WHILE AT 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 <u>9-10-58</u> to <u>9-11-58</u> and last saw her alive on <u>9-11-58</u> Death occurred at <u>7:30 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE (Degree or title) <u>A. H. Schudson D.D.</u>		22b. ADDRESS <u>Cape Girardeau Mo.</u>		22c. DATE SIGNED <u>9/13/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Sept. 12 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Ambrose Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Chaffee Mo.</u>		23e. DATE RECD. BY LOCAL REG. <u>Sept. 18, 1958</u>		23f. REGISTRAR'S SIGNATURE <u>Mrs. Homer Cooper</u>	

24. GENERAL DIRECTOR <u>Ed. Miller</u>		ADDRESS <u>Chaffee, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Sept. 18, 1958</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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 *Eugene L. Hubble* .....

Licensed Embalmer No. *5012* .....  
P. O. Address *Chaffee, 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.