

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035929-
STATE FILE NUMBER

FILED OCT 27 1958 Registration District No. 100 Primary Registration District No. 5390 Registrar's No. 92

1. PLACE OF DEATH a. COUNTY Dent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dent	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springcreek typ		c. CITY OR TOWN Salem	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION rt 3		Length of stay in lb 0330 STREET ADDRESS rt 3	
3. NAME OF DECEASED (Type or print) First Middle Last Lula B Kees		4. DATE OF DEATH Month Day Year Oct 19 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 27 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY X	11. BIRTHPLACE (City and state or country) Clay Co Ill / U S A
13a. FATHER'S NAME Wm Wilson		13b. MOTHER'S MAIDEN NAME Hattie Bendix	14. NAME OF HUSBAND OR WIFE Arthur Kees
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No X		16. SOCIAL SECURITY NO. X	17. INFORMANT Address Arthur Kees rt 3 Salem 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) metastatic carcinoma (generalized) uterine " " Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) 174X			INTERVAL BETWEEN ONSET AND DEATH 12 mos. 5 yrs.
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 <input type="checkbox"/> NOT WHILE 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 approx 1945 to 10-19-58 and last saw her alive on Oct. 2, 1958 Death occurred at 7:50 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Jas. D. Lu. Dent (Dee or title)		22b. ADDRESS Salem, Mo.	22c. DATE SIGNED 10-21-58
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	10-21-58	Cedar Grove Cem	Salem Mo
24. FUNERAL DIRECTOR Spencer Funeral Home		25. DATE RECD. BY LOCAL REG. 10/21/58	26. REGISTRAR'S SIGNATURE M. M. Hart, M. D. by R. M.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Carl H. Palmer*

Licensed Embalmer No. *237*

P. O. Address *Palmer*

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.