

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036188  
STATE FILE NUMBER

FILED NOV 5 1958 Registration District No. 139 Primary Registration District No. 5536 Registrar's No. 71

1. PLACE OF DEATH a. COUNTY <b>HOLT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>HOLT</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>LEWIS TWP</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>MOUND CITY</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>PLEASANT HILL</b>		Length of stay in lb <b>14 Mos.</b>	STREET ADDRESS (If outside, give location) <b>0448</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>LEVI</b> Middle <b>ACHREY</b> Last <b>CUBBAGE</b>			4. DATE OF DEATH Month <b>OCT.</b> Day <b>27</b> Year <b>1958</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 24, 1882</b>	9. AGE (In years) <b>75</b> (If birthday)	FUNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>FARMER</b>	11. BIRTHPLACE (City and state or country) <b>HOLT COUNTY, MO</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>JAMES CUBBAGE</b>	13b. MOTHER'S MAIDEN NAME <b>ESTELLA FREED</b>	13c. NAME OF HUSBAND OR WIFE <b>ETHEL CUBBAGE</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>MRS. DOROTHY BOONE</b> Address <b>3121 AVE. E COUNCIL BLUFFS IA.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vas Accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cerebral Thrombosis</b>		<b>9 wks</b>
	DUE TO (c) <b>332X</b>		
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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
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20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from **July 4, 1956** to **Oct 7, 1958** and last saw her alive on **Oct 26, 1958**  
Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>D. J. Sweeney M.D.</b>	22b. ADDRESS <b>Osage, Mo.</b>	22c. DATE SIGNED <b>10/28/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>10-29-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NORTH BETHEL CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>HOLT COUNTY - MO.</b>
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24. FUNERAL DIRECTOR <b>James Crawford, Mound City, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>10/28/1958</b>	26. REGISTRAR'S SIGNATURE <b>James Crawford</b>
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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.

0930 07 1931

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 *James Crawford* .....

Licensed Embalmer No. *4796* .....

P. O. Address *Mound City* .....

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.