

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-041113

STATE FILE NUMBER

FILED NOV 24 1958

Registration District No. 295 Primary Registration District No. 6015 Registrar's No. 361

300  
1-57

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Randolph</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Randolph</b>                   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>Salt Spring Township</b>   |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  | c. CITY OR TOWN <b>Moberly Mo</b>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br><b>Pleasant View Rest Home</b>  |                                  | Length of stay in 1b  | d. STREET ADDRESS (If outside, give location)<br><b>08830</b>   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Dorcas</b> Middle <b>Cave</b> Last <b>Cave</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>Nov</b> Day <b>16</b> Year <b>1958</b>   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan 14 1878</b>  |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b>  |                                  | 9b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday)<br><b>80</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><b>Randolph Co. d</b>   |
| 12. CITIZENSHIP OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                                  | 13a. FATHER'S NAME<br><b>James Rucker</b>   |   |
| 13b. MOTHER'S MAIDEN NAME<br><b>Sarah Smith</b>  |                                  | 14. NAME OF HUSBAND OR WIFE<br><b>Widowed</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT<br><b>Glen Burke</b> Address <b>Higbee Mo</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Medullary Paralysis</b>  |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Metastatic Carcinoma of chest &amp; Bones</b>  |                                  |   | <b>unknown</b>  |
| DUE TO (c) <b>Primary Carcinoma Undetermined</b>   |                                  |   | <b>unknown</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?<br>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.)<br><b>1992</b> |
| 20c. TIME OF INJURY<br>Hour _____ Month, Day, Year _____<br>a.m. _____<br>p.m. _____   |                                  |   |   |
| 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   |
| 21. I attended the deceased from <b>June 1, 1958</b> to <b>Nov 16, 1958</b> and last saw her alive on <b>Nov. 15, 1958</b><br>Death occurred at <b>7:00 PM.</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |   |
| 22a. SIGNATURE<br><b>Morris C. Topley</b>  |                                  | 22b. ADDRESS<br><b>Huntsville</b>   | 22c. DATE SIGNED<br><b>11-18-58</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>Nov 18 1958</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>City</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>Higbee Mo</b>   |
| 24. FUNERAL DIRECTOR<br><b>Burton Funeral Home. Higbee Mo</b>  |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>11-19-1958</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Mary H. Bentley</b>   |

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 *W. Tremont*

Licensed Embalmer No. *3978*  
P. O. Address *Glasgow,*

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.