

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043498
State File No.

FILED DEC 24 1958 REG. DIST. NO. 59 PRIMARY REG. DIST. NO. 4098 Registrar's No. 177

1. PLACE OF DEATH a. COUNTY Cass		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cass	
b. CITY (If outside corporate limits, write RURAL and give township) Richards Gebaur AFB		c. CITY (If outside corporate limits, write RURAL and give township) 0190	
c. LENGTH OF STAY (in this place) 6 mos.		d. STREET ADDRESS (If rural, give location) Gray Goose Trailer Court	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 328th USAF Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Lena	b. (Middle) (NMI)	c. (Last) Hall	4. DATE OF DEATH (Month) (Day) (Year) Dec 9 58
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5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 10 October 1907	9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Clay, West Va	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Scott, Bragg	13b. MOTHER'S MAIDEN NAME Nannie Adkins	14. NAME OF HUSBAND M/Sgt Miranda Y. Hall
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. 233-48-7344	17. INFORMANT'S SIGNATURE OR NAME ADDRESS M/Sgt Miranda Y. Hall 404th Field Training Det, RG AFB, Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Breast with cerebral metastasis		
	II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 170X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 15 Oct, 1958, to 9 Dec, 1958, that I last saw the deceased alive on 9 Dec, 1958, and that death occurred at 1:30 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Shannon A. Hoover, Capt USAF (MC)	23b. ADDRESS 328th USAF Hosp, Richards Gebaur AFB Mo	23c. DATE SIGNED 9 Dec 58
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12-10-58	24c. NAME OF CEMETERY OR CREMATORY Blacksville
24d. LOCATION (City, town, or county) (State) Blacksville, West Virginia	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E.K. George & Sons Inc, Grandview, Mo.	

DATE REC'D BY LOCAL REG. 12/18/1958	REGISTRAR'S SIGNATURE Mrs Ray Sebee
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 7 1958

DEC 22 1958
CLATSOP COUNTY
HEALTH DEPARTMENT

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.
Signed *Stetson Goodard*

Licensed Embalmer No. *4911*
P. O. Address *Grandview*

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 this body is not embalmed, fact should be so stated above.