

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045341

STATE FILE NUMBER

FILED DEC 23 1958

94276-58 Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 457

S. 300
1-57

| | | | | | |
|---|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY St. Francois | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Francois | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Twp. | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN ROUTE #3 | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mineral Area | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) Farmington | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) DEBBIE LEA MORICE | | | 4. DATE OF DEATH Month DEC Day 14 Year 1958 | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec 10 1958 | | 9. AGE (In years last birthday) 4 da |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) MINERAL AREA OSTEOPATHIC HOSPITAL USA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13a. FATHER'S NAME Leroy Morice | | 13b. MOTHER'S MAIDEN NAME Rhonda Francis | |
| 14. NAME OF HUSBAND OR WIFE None | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Leroy Morice C/o Truck Transport | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage | | INTERVAL BETWEEN ONSET AND DEATH 4 1/2 day | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Bush injury | | DUE TO (c) Brow Presentation | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7600 | | 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 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 Farmington | | COUNTY St. Francois | | STATE Missouri | |
| 21. I attended the deceased from Dec 10 - 1958 to Dec 14, 1958 and last saw ^{her} alive on Dec 14, 1958 Death occurred at 11:00 pm m on the date stated above; and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE L. M. Stanfield DO (Degree or title) | | 22b. ADDRESS Farmington, Mo | |
| 22c. DATE SIGNED 12-16-58 | | 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE Dec 16 1958 | |
| 23c. NAME OF CEMETERY OR CREMATORY Hill View Memorial | | 23d. LOCATION (City, town, or county) Farmington Mo | | (State) | |
| 24. FUNERAL DIRECTOR Gozean Farmington Mo | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. Dec 16, 1958 | |
| 26. REGISTRAR'S SIGNATURE Ether Rudloff | | | | | |

(Licensed Embalmer's Statement on Reverse Side)

Secretary, examiner, 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
Licensed Embalmer No. 04094
P. O. Address Farmington

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.