

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-047068

STATE FILE NUMBER

FILED FEB 2 1958

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 29

300 4
1-57

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN POPLAR BLUFF ⁰¹²⁴ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CLARK NURS. HOME		Length of stay in lb 2 mo	d. STREET ADDRESS (If outside, give location) 2106 BARRON RD Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LEORA Middle BELL Last MCCREA			4. DATE OF DEATH Month 12 Day 30 Year 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-1889	9. AGE (In years at birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) CALIF.		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME FRANK FENTIMAN		13b. MOTHER'S MAIDEN NAME ALICE		14. NAME OF HUSBAND OR WIFE WM. H. MCCREA	
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.	17. INFORMANT Clyde McCrea - Poplar Bluff Mo Address		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia 12 hrs.			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Thyroiditis 5 yrs.			
DUE TO (c) arteriosclerosis generalized 15 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Osteoarthritis 4221			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 **Sept. 1957** to **Dec 30, 1958** and last saw her alive on **30 Dec, 1958**
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Cyril A. Post M.D. (Degree or title)		22b. ADDRESS Poplar Bluff, Mo		22c. DATE SIGNED 17 Jan 59	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 1-1-58	23c. NAME OF CEMETERY OR CREMATOR MEMORIAL PARK		23d. LOCATION (City, town, or county) (State) SIKESTON MO	
24. FUNERAL DIRECTOR Welsh Funeral Home-Sikeston Mo ADDRESS		25. DATE RECD. BY LOCAL REG. 1/24/59		26. REGISTRAR'S SIGNATURE [Signature]	

All diseases in Part I must be causally related. **Steno 5, 6, 7 added by query of Jan. dis. 3-6-59** USE ONLY BLACK INK OR RIBBON TO REWRITE IF POSSIBLE

FEB 20 1959

RECEIVED

JAN 28 1959

BUTLER CO. HEALTH CENTER

FILE No. _____

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Leicester Mo

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.

38-41

34