Health, Welfare Public Service

300 C 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002620
STATE FILE NUMBER

FILED FEB 11 1959 Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 40

1. PLACE OF DEATH
a. COUNTY: St. Francois
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Bonne Terre — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Bonne Terre Hosp — Length of stay in Ib: 48 hours

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Francois
c. CITY OR TOWN: Desloge 0740 — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 508 S Lincoln — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Mable Middle: Marie Last: Walters

4. DATE OF DEATH: Month Feb. Day 2nd. Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: July 21, 1924
9. AGE (In years last birthday): 34 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Desloge, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Henry Englemen
13b. MOTHER'S MAIDEN NAME: Bessie May Jones
14. NAME OF HUSBAND ~~OR WIFE~~: William Walters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 489 26 6892
17. INFORMANT: Bonne Terre Hosp. Address: Bonne Terre, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: Known Since 4-11-58
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Original site-Carcinoma of Cervix — to 2-2-59
DUE TO (c): 171 X
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 [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 4-11-58 to 2-2-59 and last saw her alive on 2-2-59
Death occurred at 8:40 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: J. L. Foster (Degree or title) MD
22b. ADDRESS: 1000 N. Main, Desloge, Mo.
22c. DATE SIGNED: 2-4-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2/5/1959
23c. NAME OF CEMETERY OR CREMATORY: St. Francois Mem. Park
23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR: Boyer & Son ADDRESS: Desloge, Mo.
25. DATE RECD. BY LOCAL REG.: Feb 5, 1959
26. REGISTRAR'S SIGNATURE: Esther Rudloff

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 B. T. Boyer

Licensed Embalmer No. 3660

P. O. Address Desloge, 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.