Health, Welfare Public Service
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004468
STATE FILE NUMBER

FILED FEB 24 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 79

1. PLACE OF DEATH
a. COUNTY: BOONE
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Columbia — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): ELLIS FISCHEL STATE CANCER HOSPITAL — Length of stay in 1b: 16 HOURS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: TANEY
c. CITY OR TOWN: HOLLISTER 1060 — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): — Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First HATTIE Middle PEARL Last BAGGETT
4. DATE OF DEATH: Month 2 Day 14 Year 59
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]
8. DATE OF BIRTH: 2-26-07
9. AGE (In years last birthday): 51 — 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): ILLINOIS
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME: RUFUS VAUGHN
13b. MOTHER'S MAIDEN NAME: SOFIA FERNANS
14. NAME OF HUSBAND OR WIFE: DECEASED
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.: —
17. INFORMANT: HOSPITAL RECORDS Address:

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): Hemorrhagic shock — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Gastric ulcer — 6 mos.
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): anemic anoxia due to profound anemia 5400
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]
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 2-13-59, to 2-14-59 and last saw her alive on 2-14-59
Death occurred at 2:25 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): E J Schewe Jr MD
22b. ADDRESS: State Cancer Hospital
22c. DATE SIGNED: 2-14-59

23a. BURIAL, CREMATION, REMOVAL (Specify): —
23b. DATE: February 16, 59
23c. NAME OF CEMETERY OR CREMATORY: UN Known
23d. LOCATION (City, town, or county): California (State) Mo

24. FUNERAL DIRECTOR: Earl Bowlin ADDRESS: California, Mo
25. DATE RECD. BY LOCAL REG.: Feb 14, 59
26. REGISTRAR'S SIGNATURE: Mrs R E Palmer

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, Coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

MAR 3 1959

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 Earl Bowlin

Licensed Embalmer No. 2126

P. O. Address California, 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.