

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008626  
STATE FILE NUMBER

FILED MAR 6 1959

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 30

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Phelps</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rolla</u> <u>Rolla</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Rolla</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>110 Park St.,</u> Length of stay in 1b <u>Years</u>		d. STREET ADDRESS (If outside, give location) <u>110 Park St.,</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LULU MAY LIGHT</u>			4. DATE OF DEATH Month Day Year <u>Feb. 22, 1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 14, 1891</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>xx</u>	9. AGE (In years last birthday) <u>68</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>xx</u>	11. BIRTHPLACE (City and state or country) <u>Phelps County, Mo.,</u>
13a. FATHER'S NAME <u>Frederick Allison</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Putman</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
14. NAME OF HUSBAND OR WIFE <u>John Light, Deceased</u>		17. INFORMANT Address <u>Elmer Allison, Lecom, Missouri</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>xx</u>		16. SOCIAL SECURITY NO. <u>None</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>degenerative heart disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary tuberculosis 4921A</u>			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 a.m. p.m. Month, Day, Year		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 COUNTY STATE	
21. I attended the deceased from <u>2/22/59</u> to <u>2/22/59</u> and last saw her alive on <u>2/22/59</u> Death occurred at <u>1:10AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dr. R. J. Smith</u>		22b. ADDRESS <u>Rolla Mo</u>	
22c. DATE SIGNED <u>2/22/59</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 23 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rhea Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Near; Rolla, Missouri.</u>
24. FUNERAL DIRECTOR By <u>Paul E. Null</u> ADDRESS <u>Null &amp; Son, Funeral Home.. Rolla</u>		25. DATE RECD. BY LOCAL REG. <u>Feb. 24, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Nadine L. Stoll</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 ..... *Paul E. Null*

Licensed Embalmer No. 4498  
P. O. Address Rolla, 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.