

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008413  
STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 139

FILED MAR 30 1959

1. PLACE OF DEATH a. COUNTY <u>BOONE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Benton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>COLUMBIA, Mo.</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Edwards</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>M.U. Medical Center</u>	Length of stay in lb <u>2.5 day</u>	d. STREET ADDRESS (If outside, give location) <u>Route 1</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>LETA Loop LUSTER</u>			4. DATE OF DEATH Month Day Year <u>Mar. 25 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</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>12-21-21</u>		9. AGE (in years last birthday) <u>37</u> 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) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and state or country) <u>Fristo, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Archie Loop</u>		13b. MOTHER'S MAIDEN NAME <u>Mabel Salisbury</u>		14. NAME OF HUSBAND OR WIFE <u>Roy Luster</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>M.U. Hospital Records</u>	

18. CAUSE OF DEATH (Enter only one cause on line or (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Congestive failure</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Essential Malignant Hypertension</u>		19. WAS AUTOPSY PERFORMED? 1 YES <input checked="" type="checkbox"/> NO <input 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 WORK <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>3/2/59</u> to <u>3/25/59</u> and last saw her alive on <u>3/25/59</u> Death occurred at <u>1:20 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE (Degree & title) <u>Chas B. Sparks, M.D.</u>		22b. ADDRESS <u>University Hospital</u>		22c. DATE SIGNED <u>3/25/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>3-25-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fristo Cem Fristo Mo</u>	
		23d. LOCATION (City, town, or county) (State) <u>WARSAW, Mo</u>			

24. FUNERAL DIRECTOR ADDRESS <u>Parsons Funeral Service, Columbia Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Mar 25 1959</u>		26. REGISTRAR'S SIGNATURE <u>Max R E Palmer</u>	
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

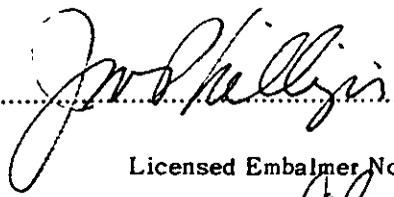
MEDICAL CERTIFICATION

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. 4897

P. O. Address Columbus, 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.