

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008436
STATE FILE NUMBER

FILED APR 14 1959

Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 15

300
1-57

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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>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Centralia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Centralia</u> <u>0100</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>Way Nursing Home</u> Length of stay in 1b <u>16 Mo.</u>		d. STREET ADDRESS (If outside, give location) <u>Way Nursing Home</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Laura Stephens Newcomer</u>			4. DATE OF DEATH Month Day Year <u>April - 6 - 1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> - 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22 - 1869</u>
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>Housewife</u>	9. AGE (In years to nearest day) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>89</u> Months <u>5</u> Days <u>14</u> Hours <u></u> Min. <u></u>
11. BIRTHPLACE (City and state or country) <u>Boone County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Anderson Wright Shelton</u>		13b. MOTHER'S MAIDEN NAME <u>Sally Ann Stephens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year & date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>John L. Stephens</u>		Address <u>Centralia, Mo.</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>Cerebral hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension, arterial</u>			<u>5 months</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>331x</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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 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>May 1946</u> to <u>6 Apr. 1959</u> and last saw <u>her</u> alive on <u>5 April 1959</u> Death occurred at <u>12:45</u> P on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>L. Lachance, M. D. L. Lachance, M.D.</u>		22b. ADDRESS <u>Centralia, Missouri</u>	
		22c. DATE SIGNED <u>4/7/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April - 7 - 1959</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Centralia Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Centralia, Mo.</u>	
24. FUNERAL DIRECTOR <u>Paul O. Ballou, Centralia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>April 7 - 1959</u>	
26. REGISTRAR'S SIGNATURE <u>Maud Mc Bride</u>			

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

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.

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 S. Ballen*

Licensed Embalmer No. *4206*
P. O. Address *Centralia, 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.