

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008652

STATE FILE NUMBER

FILED MAR 23 1959

Registration District No.

53

Primary Registration District No.

3010

Registrar's No.

96

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau Mo</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Illinois</u> b. COUNTY <u>Alexander</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Thebes Illinois</u>		c. CITY OR TOWN <u>Thebes Illinois</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Francis Hospital</u>		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) First <u>Berdie</u> Middle <u>Waddell</u> Last <u>Waddell</u>		4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>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"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11. BIRTHPLACE (City and state or country) <u>Tunnel Hill Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Jim Johnson</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Lambert</u>	
14. NAME OF HUSBAND OR WIFE <u>Elijah Waddell Deceased</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>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Eugene Baker Thebes Illinois</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>Bronch. pneumonia (extensive)</u> DUE TO (b) <u>Carcinoma of the breast</u> DUE TO (c) <u>(Rt) with extensive metastases</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Poker spine - Kyphos-scoliosis, gen debility, etc.</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II or from 18.) <u>491XH</u>	
20c. TIME OF INJURY Hour <u>9:30</u> Month, Day, Year <u>March 16, 1959</u>		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 <u>Thebes Illinois</u>	
21. I attended the deceased from <u>March 16, 1959</u> to <u>March 17, 1959</u> and last saw her alive on <u>March 17, 1959</u> Death occurred at <u>9:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Arthur M. Carter M.D.</u>		22b. ADDRESS <u>714 Broadway, Cape Girardeau, Mo.</u>	
22c. DATE SIGNED <u>3/20/59</u>		23. LOCATION (City, town, or county) (State) <u>Thebes Illinois</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/19/59</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemt</u>		23d. LOCATION (City, town, or county) (State) <u>Thebes Illinois</u>	
24. FUNERAL DIRECTOR <u>I.L.Haman Cape Girardeau Mo</u>		25. DATE RECD. BY LOCAL REG. <u>3-20-59</u>	
26. REGISTRAR'S SIGNATURE <u>Jimmie Kasten</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Health, Welfare, Public Service

300  
1-57

Doctor, coroner, etc. must use only standard nomenclature in items 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. 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 *J. H. Haman* .....

Licensed Embalmer No. 2863 .....

P. O. Address Cape Girardeau I .....

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.