

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009207

STATE FILE NUMBER

FILED MAR 19 1959

Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 21

300
-57

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Howard	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fayette, Missouri		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Fayette <u>04510</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 Lee Hospital		Length of stay in 1b 15 hrs	d. STREET ADDRESS (If outside, give location) 609 W. Elm Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First DOROTHY Middle FERN Last SABIN			4. DATE OF DEATH Month MAR. Day 10, Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1912
9. AGE (In years, less birthday) 47		10. FUNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Mgr.		10b. KIND OF BUSINESS OR INDUSTRY R.E.A.	11. BIRTHPLACE (City and state or country) Howard County, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Edward Frank McLaughlin	
13b. MOTHER'S MAIDEN NAME Katie Groce		14. NAME OF HUSBAND OR WIFE James Clark Sabin Jr.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 489-30-2115	17. INFORMANT Address James C. Sabin Fayette, Missouri
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>Carcinoma Breast</u> <u>& metastasis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH Oct '59
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 170X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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 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>Oct '57</u> to <u>3-10-59</u> and last saw her alive on <u>3-10-59</u> Death occurred at <u>8 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>M. P. Keech M.D.</u> (Name or title)		22b. ADDRESS <u>Fayette, Mo</u>	
22c. DATE SIGNED <u>3/12/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3/13/1959	23c. NAME OF CEMETERY OR CREMATORY Washington Cemetery	23d. LOCATION (City, town, or county) (State) Glasgow, Missouri
24. FUNERAL DIRECTOR <u>Ralph A. Carr</u> ADDRESS Fayette, Mo.		25. DATE RECD. BY LOCAL REG. 3-12-59	26. REGISTRAR'S SIGNATURE <u>Mary L. Shell</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 with no relation. All diseases in Part I must be causally related.

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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 *Joseph A. Carr*

Licensed Embalmer No. *3340*

P. O. Address *Fayette, 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.