

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012762

STATE FILE NUMBER

FILED MAY 11 1959 Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 63

1. PLACE OF DEATH a. COUNTY <u>Cooper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Boonville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Arrow Rock</u> c. 970 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>St. Joseph's Hosp.</u>		Length of stay, in 1b <u>3 months</u>	d. STREET ADDRESS (If outside, give location) <u>Streets Not Numbered</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORA PEARL CRAIG HUBBARD</u>			4. DATE OF DEATH Month Day Year <u>MAY 5 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>Dec. 10, 1883</u>
9. AGE (In years last birthday) <u>75</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>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Arrow Rock, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Stephen Craig</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary Catherine Stafford</u>		14. NAME OF HUSBAND OR WIFE <u>-----</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>Ruby C. Ferguson</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>Bronchopneumonia - Terminal</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 2 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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>Arteriosclerosis Heart Disease Pernicious anemia Osteomyelitis of Cervical</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 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>1-15-59</u> to <u>5-5-59</u> and last saw her alive on <u>5-5-59</u> Death occurred at <u>11:15 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>B. M. Stuart, M.D.</u>		22b. ADDRESS <u>329 Main; Boonville Mo.</u>	
22c. DATE SIGNED <u>5-5-59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>5-6-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arrow Rock Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Arrow Rock, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Campbell-Lewis</u>		ADDRESS <u>Marshall, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>5/6/59</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

SEP 1960

SEP 5 1960

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 *Armed A Lewis*.....

Licensed Embalmer No. *4709*.....
P. O. Address *Marshall, Me*.....

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.