

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020156

STATE FILE NUMBER

health,  
Welfare  
Public  
Service

300  
1-56

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All symptoms will be listed. All

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Registration District No. 381 Primary Registration District No. 4815 Registrar's No. 47

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>SUTTON</u>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>ILLINOIS</u> COUNTY <u>ROCK ISLAND</u>                 |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MILAN</u><br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   | c. CITY OR TOWN <u>MOZINE</u><br>8120<br>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>SUTTON CO MEMO HOSP</u><br>Length of stay in lb  |   | d. STREET ADDRESS <u>3917-25AUIZ</u> (If outside, give location)<br>Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>                 |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>WILLIE</u> Middle <u>MAXINE</u> Last <u>LOYANT</u>  |   | 4. DATE OF DEATH<br>Month <u>MAY</u> Day <u>27</u> Year <u>1959</u>   |  |
| 5. SEX <u>FE</u>  | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>JUNE 6, 1922</u>                            |
| 9. AGE (In years last birthday) <u>36</u>   |   | IF UNDER 1 YEAR<br>Months _____ Days _____  | IF UNDER 24 HRS.<br>Hours _____ Min. _____                         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><u>FAIRLAND OKLA</u> |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   | 13. FATHER'S NAME<br><u>ROBERT EDWARD LEE</u>   |  |
| 14. MOTHER'S MAIDEN NAME<br><u>VERNA LAVERIE SANDERS</u>  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>                                      |  |
| 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |   | 17. INFORMANT<br>Address<br><u>MRS VERNA CASSTY MILAN</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma sigmoid</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 mos</u>                  |
| 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.)<br><u>1533</u> |   |  |
| 20c. TIME OF INJURY<br>Hour _____ a. m. _____ p. m.<br>Month, Day, Year _____   | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                   |   |  |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE   |   |  |
| 21. I attended the deceased from <u>May 2, 1959</u> , to <u>May 27</u> and last saw <sup>her</sup> <del>him</del> alive on <u>May 27, 1959</u><br>Death occurred at <u>4108A</u> on the date stated above; and to the best of my knowledge, from the causes stated.   |   |   |  |
| 22a. SIGNATURE (Degree or title)<br><u>Earl Simpson D.O.</u>  |   | 22b. ADDRESS<br><u>Milans, MO</u>   | 22c. DATE SIGNED<br><u>5-28-59</u>                                 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BYRDAL</u>  | 23b. DATE<br><u>MAY 29, 1959</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>oakwood</u>  | 23d. LOCATION (City, town, or county) (State)<br><u>MILAN MO</u>   |
| 24. FUNERAL DIRECTOR<br><u>Deppen Funeral Home Milan</u><br>ADDRESS   |   | 25. DATE RECD. BY LOCAL REG.<br><u>6-1-59</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Mrs. M. W. Deebert</u>             |

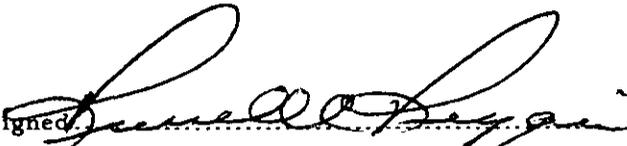
(Licensed Embalmer's Statement on Reverse Side)

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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  .....

Licensed Embalmer No. 37

P. O. Address 

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.