

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024669

FILED VS AUG 7 1959 *709*

Primary Registration District No. *4180* Registrar's No. *31*

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Dunklin b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Campbell Length of stay in 1b 3 yrs c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen. Baptist Rest Home Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dunklin c. CITY OR TOWN Campbell Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Campbell, Missouri Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
---	--	---	--

3. NAME OF DECEASED (Type or print) First ADDALINE Middle ELVIRA Last LOGSDON			4. DATE OF DEATH Month July Day 23 Year 1959				
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Oct 13, 1870	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Shawneetown, Ill.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Patrick Lawler			13b. MOTHER'S MAIDEN NAME Margaret Crenshaw			14. NAME OF HUSBAND OR WIFE deceased	
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. none		17. INFORMANT Hubert Hogsdon, Florrisant, Mo.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Hypostatic Pneumonia DUE TO (b) Carcinoma of Uterine Fundus DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 days ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Hypertensive Cardio-Vascular Disease - left hemiplegia		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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 a.m. p.m.	Month, Day, Year		
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>5/25/59</u> to <u>7/23/59</u> and last saw her ^{her} alive on <u>7/23/59</u> Death occurred at <u>7</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Wallace Belsky M.D.		22b. ADDRESS Campbell Mo.	22c. DATE SIGNED 7/28/59
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE July 25, 1959	23c. NAME OF CEMETERY OR CREMATORY Rocky Hill Cemetery	23d. LOCATION (City, town, or county) (State) Campbell, Mo. Rt. 2
24. FUNERAL DIRECTOR ADDRESS Landess Funeral Home, Campbell, Mo.		25. DATE RECD. BY LOCAL REG. 7-29-1959	26. REGISTRAR'S SIGNATURE Mr. Hubert Campbell

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Christine M. Landes

Licensed Embalmer No. 4227

P. O. Address Compton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.