

R1 DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 24 1959

59-028175

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 362

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>BOONE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>HOWELL</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>COLUMBIA</u>		Length of stay in 1b <u>3 DAYS</u>	c. CITY OR TOWN <u>WILLOW SPRINGS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>ELLIS FISCHER STATE CANCER HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>NONE GIVEN</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>-OLA</u> Middle <u>MAY</u> Last <u>WAKE</u>	4. DATE OF DEATH Month <u>AUG.</u> Day <u>15</u> Year <u>1959</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-21-01</u>	9. AGE (last birthday) <u>58</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel Maid</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>TEXAS COUNTY MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>American</u>
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13a. FATHER'S NAME <u>OWEN ADKINS</u>	13b. MOTHER'S MAIDEN NAME <u>MARY PRUITT</u>	14. NAME OF HUSBAND OR WIFE <u>T. MANUEL WAKE</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>	16. SOCIAL SECURITY NO. <u>NONE GIVEN</u>	17. INFORMANT Address <u>HOSPITALS RECORD</u>
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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>Adeno-Carcinoma Cervix metastatic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 + yrs</u>
DUPLICATE CAUSE (b) <u>Adeno-Carcinoma Cervix metastatic</u>		
DUPLICATE CAUSE (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Anemia</u>	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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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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
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21. I attended the deceased from Aug 12-59 to Aug 15-59 and last saw her/him alive on Aug 15-59
Death occurred at 7:15 pm 15 Aug '59 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Patricia S. Graham</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>State Cancer Hosp. Columbia</u>	22c. DATE SIGNED <u>15 Aug</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>General</u>	23b. DATE <u>8-17-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Willow Springs</u>	23d. LOCATION (City, town, or county) <u>Willow Springs, Mo.</u> (State) <u>MO</u>
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24. FUNERAL DIRECTOR <u>Lyman Sprinkle</u> ADDRESS <u>Columbia, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Aug 16 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6961 4 8 9771

NOV 3 1959

SEP 27 1959

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

Lynna Spunkle

Licensed Embalmer No. 4013

P. O. Address Columbia,

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