

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032182

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 61 Primary Registration District No. 4107 Registrar's No. 15

STATE FILE NUMBER

AMENDED

FILED SEP 28 1961

1. PLACE OF DEATH a. COUNTY <u>Cedar</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Cedar</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>El Dorado Springs</u>		c. CITY OR TOWN <u>El Dorado Springs</u>	
Length of stay in 1b <u>5 Da.</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 <u>Cedar Co. Mem. Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>409 S. Kirkpatrick</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Della</u> Middle <u>Victoria</u> Last <u>Teague</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>18</u> Year <u>1961</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>7-7-1882</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
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		11. BIRTHPLACE (City and state or country) <u>Harrisonville, Mo. U.S.A.</u>	
13a. FATHER'S NAME <u>John Moore</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Briles</u>		14. NAME OF HUSBAND OR WIFE <u>Floyd Teague</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.		17. INFORMANT Address <u>Lucille Tolle, El Dorado Springs, Mo</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>Cardio-renal failure</u> DUE TO (b) <u>Traumatic shock.</u> DUE TO (c) <u>Fracture of rt. femur.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.) <u>Pt. fell at home (slipped on floor)</u>			
20c. TIME OF INJURY Hour <u>2:30</u> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> Month, Day, Year <u>Sept. 13, 1961</u>					

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.) <u>home</u>	20f. CITY, TOWN, OR LOCATION <u>El Dorado Springs, Cedar, Missouri</u>	20g. COUNTY <u>Cedar</u>	20h. STATE <u>Missouri</u>
21. I attended the deceased from <u>13 Sept 1961</u> to <u>18 Sept 1961</u> and last saw <u>her</u> live on <u>18 Sept 1961</u> Death occurred at <u>Cedar City, Mo.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22. SIGNATURE <u>Shelly R. Murphy M.D.</u>		22b. ADDRESS <u>El Dorado Springs, Mo. Professional Bldg.</u>		22c. DATE SIGNED <u>9/19/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-20-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hazel Dell Cemetery</u>	23d. LOCATION (City, town, or county) <u>Cedar Co., Missouri</u>	
24. FUNERAL DIRECTOR <u>Gwinn-Carothers, El Dorado Springs, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-19-61</u>	26. REGISTRAR'S SIGNATURE <u>DAVE GASSIOT</u>	

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

**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 May W. Dickering

Licensed Embalmer No. 4696

P. O. Address El Dorado

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.