

FILED APR 4 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8837

BIRTH NO. _____		REG. DIST. NO. 156		PRIMARY REG. DIST. NO. 2004		Registrar's No. 134	
1. PLACE OF DEATH a. COUNTY JASPER				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JASPER			
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN JOPLIN		c. LENGTH OF STAY (in this place) 55 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JOPLIN			
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S				d. STREET ADDRESS (If rural, give location) 2020 Joplin			
3. NAME OF DECEASED (Type or Print) Pearl		a. (First) Pearl		b. (Middle) M.		c. (Last) Leib	
4. DATE OF DEATH (Month) (Day) (Year) 3 17 49		5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH Oct. 12, 1886		9. AGE (In years last birthday) 62		IF UNDER 1 YEAR Months 5 Days 5		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY housewife		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Perry Snow		13b. MOTHER'S MAIDEN NAME Laura Hogan		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Walter Leib, Webb, City, Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastric hemorrhage,		ANTECEDENT CAUSES DUE TO (b) malignancy of stomach.				194X	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) surgery, Feb 1 1949. Laboratory findings, Krukenbergs tumors of the ovaries with metastatic adenocarcinoma in the corpus uteri.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) None		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased _____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title)				23b. ADDRESS		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-19-49		24c. NAME OF CEMETERY OR CREMATORY Mt. Hope		24d. LOCATION (City, town, or county) (State) Joplin, Mo.	
DATE REC'D BY LOCAL REG 3-21-49		REGISTRAR'S SIGNATURE Ed. N. James		FUNERAL DIRECTOR'S SIGNATURE Barker-Hunsaker Mortuary		ADDRESS Joplin, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

49
21
51

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.

Signed F. M. Jones

Licensed Embalmer No. 2319

Signed _____
Student Embalmer

P. O. Address Joplin Mo

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 this body is not embalmed, fact should be so stated above.