

FILED APR 11 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7842

| | | | | | | | | |
|---|----------------------------------|---|---|---|---|--|---|----------------------------------|
| BIRTH NO. _____ | | REG. DIST. NO. 128 | | PRIMARY REG. DIST. NO. 2000 | | Registrar's No. 306 | | |
| 1. PLACE OF DEATH a. COUNTY <u>Greene</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before ad admission) a. STATE <u>Missouri</u> b. COUNTY <u>Darwin 0550</u> | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u> | | c. LENGTH OF STAY (In this place) <u>73 days</u> | | c. CITY OR TOWN <u>Cassville</u> | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Burgess Hospital</u> | | | | e. STREET ADDRESS (If rural, give location) <u>Cassville, Missouri</u> | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Mabel</u> | | | b. (Middle) _____ | | c. (Last) <u>Messer</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>April 4 1955</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u> | 8. DATE OF BIRTH <u>March 11 - 1892</u> | | 9. AGE (In years, last birthday) <u>63</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>24</u> | IF UNDER 24 HRS. Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Sec. To State Senator Missouri</u> | | 11. BIRTHPLACE (City and State or Foreign Country) <u>0</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13a. FATHER'S NAME <u>Melville C Messer</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mary P Boyless</u> | | 14. NAME OF HUSBAND OR WIFE <u>Single</u> | | | | |
| 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>UNKNOWN</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Hospital Records</u> | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Malignant Melanoma</u> | | | | DUPLICATE (b) <u>with generalized metastases to lungs, skin and all abd. organs. Hemipia</u> | | | | <u>1 yr</u> |
| ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | DUPLICATE (c) _____ | | | | <u>1 wk</u> |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | _____ | | | | _____ |
| 19a. DATE OF OPERATION <u>May 6 1954 (Mayo)</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>Excision of melanoma - arm</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Excision of melanoma - arm</u> | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>190 X</u> | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>190 X</u> | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? _____ | | | | |
| 22. I hereby certify that I attended the deceased from <u>Sept 10, 1954</u> , to <u>Apr 4, 1955</u> , that I last saw the deceased alive on <u>Apr 4, 1955</u> , and that death occurred at <u>1 A.M.</u> , from the causes and on the date stated above. | | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>Chas G Lockhart MD</u> | | | | 23b. ADDRESS <u>Springfield Mo</u> | | 23c. DATE SIGNED <u>4/4/55</u> | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | | 24b. DATE <u>4-4-55</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>CASSVILLE, MO.</u> | | 24d. LOCATION (City, town, or county) (State) <u>CASSVILLE, MO.</u> | | | |
| DATE REC'D BY LOCAL REG. <u>4-4-55</u> | | REGISTRAR'S SIGNATURE <u>Edith Williamson</u> | | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>CULVER FUNERAL HOME CASSVILLE, MO.</u> | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

APR 3 1956

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. 407

P. O. Address.....

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. - -