

FILED FEB 13 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

1608

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 59

1. PLACE OF DEATH a. COUNTY <u>JASPER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JASPER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JOPLIN</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>JOPLIN</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>ST. JOHN'S HOSP.</u> Length of stay in lb <u>60 YRS</u>		d. STREET ADDRESS <u>1715 KENTUCKY AVE</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>KATE</u> Middle <u>BLANCH</u> Last <u>CAYWOOD</u>			4. DATE OF DEATH Month <u>JAN.</u> Day <u>31</u> Year <u>1957</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>FEB. 8, 1889</u>	9. AGE (In years last birthday) <u>67</u> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____	
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 <u>OWN HOME</u>	11. BIRTHPLACE (City and state or country) <u>FERNEY, S. DAK.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>HUGH NEILL</u>			14. MOTHER'S MAIDEN NAME <u>MARY HANLON</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>CARL CAYWOOD, 1715 KENTUCKY AVE.</u>		

CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary Arteriosclerosis</u>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		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 _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____		
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>Jan 29 '57</u> to <u>Jan 3 /57</u> and last saw her him alive on <u>Jan 30 '57</u> Death occurred at _____ a _____ m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>S. Schobel MD</u> (Degree or title)	22b. ADDRESS <u>Joplin MO</u>	22c. DATE SIGNED <u>2-1-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2-2-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>
23d. LOCATION (City, town, or county) (State) <u>JOPLIN, MISSOURI</u>		
24. FUNERAL DIRECTOR ADDRESS <u>STEVE PARKER MORTUARY, JOPLIN, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>Feb. 4-57</u>	26. REGISTRAR'S SIGNATURE <u>Dore Merriam</u>

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300-56

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with or without. MEDICAL CERTIFICATION: 7 Feb. 1957. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

260

County File Number 57-2-107
Date Filed FEB 11 1957

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 *F. M. Jones*.....
Licensed Embalmer No. 23

P. O. Address *John Lane*

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