

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35442

STATE FILE NUMBER

FILED NOV 4 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1036-B

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Springfield ⁸³⁹⁰	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mercy Hospital		d. STREET ADDRESS 1415 W. Brower	
Length of stay in 1b 7 years		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Mella Middle Martin Last Hall			4. DATE OF DEATH Month October Day 23 Year 1957		
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5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1874	9. AGE (In years last birthday) 82	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY self	11. BIRTHPLACE (City and state or country) Olive Hill, Kentucky	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Tivis Martin	13b. MOTHER'S MAIDEN NAME Sally Salisbury	14. NAME OF HUSBAND OR WIFE Ben Hall
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO. no	17. INFORMANT Address Mrs. Sally Hilton, Springfield, Mo.
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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) Carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH 7 weeks Over 2 years
DUE TO (b) Intra-abdominal carcinoma		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1991		

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 _____ 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 _____
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21. I attended the deceased from Death occurred at 3/14/54 to 10/23/57 and last saw her alive on 10/2/57 m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE David A. Hall, M.D. (Degree or title)	22b. ADDRESS Springfield, Mo	22c. DATE SIGNED 10/25/57
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-25-57	23c. NAME OF CEMETERY OR CREMATORY White Chapel	23d. LOCATION (City, town, or county) Springfield, Mo
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24. FUNERAL DIRECTOR Ralph Thieme	ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 10-29-57	26. REGISTRAR'S SIGNATURE Edith Williams
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Lee Mason*

Licensed Embalmer No. *4568*

P. O. Address *Springfield, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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