

FILED FEB 6 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1630

STATE FILE NUMBER

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 46

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-57

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1. PLACE OF DEATH a. COUNTY JASPER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY JASPER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JOPLIN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN JOPLIN 2496
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHNS HOSPITAL		Length of stay in lb D. O. A.	d. STREET ADDRESS (If outside, give location) 800 VANWINKLE
3. NAME OF DECEASED (Type or print) First MACK Middle ORVILLE Last HERROD			4. DATE OF DEATH Month JAN. Day 21 Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1886 JAN 23, 1886
10a. USUAL OCCUPATION (Give kind of work done during past 12 months if retired) RETIRED MINER		10b. KIND OF BUSINESS OR INDUSTRY LEAD MINING	11. BIRTHPLACE (City and state or country) NEWTON COUNTY, MO.
13a. FATHER'S NAME CARTER HERROD		13b. MOTHER'S MAIDEN NAME NO DATA	14. NAME OF HUSBAND OR WIFE INA HERROD
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 491-01-7104	17. INFORMANT Address MRS INA HERROD JOPLIN, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Valvular Heart Lesions			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4214			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 _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT <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 July 4, 1957 to Jan 6, 1958 and last saw her alive on Jan 6, 1958 Death occurred at 11 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John W. Douglas M.D.		22b. ADDRESS 210 West 32nd Joplin Mo	22c. DATE SIGNED 1/23/58
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) BURIAL	23b. DATE 1-25-58	23c. NAME OF CEMETERY OR CREMATORY CARTERVILLE CEMETERY	23d. LOCATION (City, town, or county) (State) CARTERVILLE MO.
24. FUNERAL DIRECTOR ADDRESS HEDGE-LEWIS FUNERAL HOME WEBB CITY, MO.		25. DATE RECD. BY LOCAL REG. Jan. 29-58	26. REGISTRAR'S SIGNATURE Dove Merriam

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature. All diseases in Part I must be causally related.

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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 *Richard Gray Lewis*

Licensed Embalmer No. *4405*

P. O. Address *West City, 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.