

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-011005

STATE FILE NUMBER

FILED MAR 24 1958

Registration District No. 276 Primary Registration District No. 2945 Registrar's No. 19

Health, Welfare, Public Service
0810
4
300
1-56
All 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 will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Miss. 10672</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural - N.D.</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Charleston</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>Ferndale Home</u>		d. STREET ADDRESS (If outside, give location) <u>Syrs.</u>	

3. NAME OF DECEASED (Type or print) First <u>Ellis</u> Middle <u>B.</u> Last <u>Groves</u>			4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>58</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-21-1902</u>	9. AGE (In years last birthday) <u>56</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>←</u>	11. BIRTHPLACE (City and state or country) <u>Mississippi Co., MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Hudson</u>			14. MOTHER'S MAIDEN NAME <u>Jda Clark</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>←</u>		16. SOCIAL SECURITY NO. <u>←</u>	17. INFORMANT Name <u>Ferndale Office -</u> Address <u>St. James, MO</u>		

18. 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>8 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>My just condition</u>	<u>4201</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) <u>Paralysis of lower limbs & loss of speech 5 years</u>		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 <u>5:30</u> Month, Day, Year a. m. p. m.	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from <u>7-9-1953</u> to <u>3-14-1958</u> and last saw her alive on <u>3-13-58</u> Death occurred at <u>5:30 A. m</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>C.V. Hammler, M.D.</u>	22b. ADDRESS <u>St. James,</u>	22c. DATE SIGNED <u>3-18-58</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-16-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Charleston Cem Charleston, Mo.</u>	23d. LOCATION (City, town, or county) (State) <u>Charleston, Mo.</u>
24. FUNERAL DIRECTOR <u>Nemmelde Funeral Home - Charleston, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3-18-1958</u>	26. REGISTRAR'S SIGNATURE <u>Ruth B. Powell</u>	

RECEIVED

Florida County Health Officer,

County File Number 997

Date Filed 3-11-58

MAR 25 1958

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 me, Student Embalmer No. working under my personal supervision..

Student
Signature of Student Embalmer

Signed (Oral E Lickhile)

Licensed Embalmer No.

P. O. Address

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