

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-025980  
STATE FILE NUMBER

FILED AUG 6 1958 Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 361

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Joplin		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Joplin
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hosp.		Length of stay in lb 1 wk.	d. STREET ADDRESS (If outside, give location) St. John's Hosp.
3. NAME OF DECEASED (Type or print) First Middle Last KIMBERLY ANN MC CLELLAN		4. DATE OF DEATH Month Day Year 7-31-1958	
5. SEX Female	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 7-24-1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) St. John's Hosp, Joplin
13a. FATHER'S NAME Raymond McClellan		13b. MOTHER'S MAIDEN NAME Dorothy Smittle	14. NAME OF HUSBAND OR WIFE None
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. None	17. INFORMANT Address Dorothy Smittle McClellan, Asbury 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) Prematurity Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Premature separation of the placenta DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7615			INTERVAL BETWEEN ONSET AND DEATH at birth
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 7-24-58 to 7-31-58 and last saw her alive on 7-31-58 Death occurred at 8:00 pm on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Catherine Fiehl M.D.		22b. ADDRESS Joplin Missouri	
22c. DATE SIGNED 1 August			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8-2-1958	
23c. NAME OF CEMETERY OR CREMATORY Park Cemetery		23d. LOCATION (City, town, or county) (State) Columbus, Kansas	
24. FUNERAL DIRECTOR Don Roney		ADDRESS Carl Junction	
25. DATE RECD. BY LOCAL REG. 8-1-1958		26. REGISTRAR'S SIGNATURE Dove Merriam	

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 *Jack C. Simpson* .....  
Licensed Embalmer No. *4647* .....  
P. O. Address *Webb 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.