

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-040392

STATE FILE NUMBER

FILED DEC 2 1958

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 561

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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 MISSOURI 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 <u>0495</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 ST. JOHN'S HOSP. | | Length of stay in 1b 8 YRS | d. STREET ADDRESS (If outside, give location) 3135 E. 7TH ST. | | Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First STELLA Middle MAXINE Last HOLMES | | | 4. DATE OF DEATH Month NOVEMBER Day 24 Year 1958 | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH SEPT. 1, 1922 | | 9. AGE (In years last birthday) 36 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | 11. BIRTHPLACE (City and state or country) STILLWELL, OKLA. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13a. FATHER'S NAME HENRY JOHNSON | | 13b. MOTHER'S MAIDEN NAME PEARL BISHOP | | 14. NAME OF HUSBAND OR WIFE WILLIAM S. HOLMES | |
| 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. 44-16-1946 | | 17. INFORMANT Address WILLIAM S. HOLMES 3135 E. 7TH ST. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanoma | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 months |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | |
| DUE TO (b) Generalized metastasis to | | | | | 2 months |
| DUE TO (c) liver-lungs. Skin - at leg region | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a), (b), or (c). 1909 | | | | | 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 <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> | | | | | |
| 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>9-23-58</u> to <u>11-24-58</u> and last saw her/him alive on <u>11-24-58</u> Death occurred at <u>10:15</u> <u>PM</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <i>Lewin H. Ferguson M.D.</i> | | | | 22b. ADDRESS <i>206 Med. Art. Bldg. - Joplin Mo</i> | |
| | | | | 22c. DATE SIGNED 11-25-58 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 11-26-58 | | 23c. NAME OF CEMETERY OR CREMATORY OZARK MEMORIAL PARK, | |
| | | | | 23d. LOCATION (City, town, or county) (State) JOPLIN, MISSOURI | |
| 24. FUNERAL DIRECTOR ADDRESS STEVE PARKER MORTUARY, JOPLIN, MO. | | | 25. DATE RECD. BY LOCAL REG. 11-28-1958 | | 26. REGISTRAR'S SIGNATURE <i>Worce Merriman</i> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *F. M. Jones*

Licensed Embalmer No. *2319*

P. O. Address *Joplin 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.