

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH59-000293  
STATE FILE NUMBER

FILED FEB 2 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 111

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Meth. Hosp.</b>		Length of stay in lb <b>most of life</b>		d. STREET ADDRESS <b>1520 Francis St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>ALICE</b> Last <b>HINES</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>27</b> Year <b>1959</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 30, 1898</b>		9. AGE (In years last birthday) <b>60</b>	10. FUNDING YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>office manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance Agency</b>		11. BIRTHPLACE (City and state or country) <b>Buchanan County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>unknown</b>		13b. MOTHER'S MAIDEN NAME <b>unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Lester A. Hines</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>491-24-5418</b>		17. INFORMANT Address <b>Mrs. Bearden Balding, Grandview, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Alens with Toxemia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Surgery</b>						DUE TO (c) <b>6314</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
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 <b>10:35p.</b> Month <b>1-27-59</b> Day <b>27</b> Year <b>1959</b>							
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 <b>St. Joseph</b>		STATE <b>Mo.</b>	
21. I attended the deceased from <b>1-20-59</b> to <b>1-27-59</b> and last saw her alive on <b>1-27-59</b> Death occurred at <b>10:35p.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Clement C. Duffont</b> (Degree of title)				22b. ADDRESS <b>St. Joseph Mo</b>		22c. DATE SIGNED <b>1-28-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>buried</b>		23b. DATE <b>1/30/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or country) (State) <b>St. Joseph Mo.</b>		
24. FUNERAL DIRECTOR <b>Heaton-Bowman</b> ADDRESS <b>St. Joseph, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>Jan 29, 1959</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Modell</b>		

Dr. Clement C. Duffont  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION  
 All diseases in Part I must be causally related.  
 All diseases in Part II must be causally related.

1959 FEB 9 6 33A

*Dr. Linnmont*

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 *William Spelling* .....

Licensed Embalmer No. *4535* .....

P. O. Address *St. Joseph, 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.