

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000296

STATE FILE NUMBER

JAN 12 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 20

3004
1-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph 01170 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR NURSING HOME INSTITUTION Leon Nursing Home 624 Prospect Ave		Length of stay in lb Lifetime	d. STREET ADDRESS (If outside, give location) 624 Prospect Ave Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Myrtle Middle A. Last Hubbell			4. DATE OF DEATH Month January Day 4 Year 1959.		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1894	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant	10b. KIND OF BUSINESS OR INDUSTRY State Hosp. #2.	11. BIRTHPLACE (City and state or country) St. Joseph, Missouri.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME S. H. Sollars	13b. MOTHER'S MAIDEN NAME Ida Belle Tudor	14. NAME OF HUSBAND OR WIFE Henry Lee Hubbell
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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. 542-26-4904	17. INFORMANT Warren Sollars Address St. Joseph, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma		INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Metastatic Cancer of Liver		3 months
DUE TO (c) Carcinoma		unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1562		

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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
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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
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21. I attended the deceased from **Sept 18, 1957** to **Jan 4, 1959** and last saw her alive on **Dec 21, 1958**
Death occurred at **12:05 P.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Sharon E. Waggoner M.D.	22b. ADDRESS 301 Illinois Ave St. Joseph Missouri	22c. DATE SIGNED 1/6/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 8, 1959.	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri.
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24. FUNERAL DIRECTOR Meierhoffer & Telema ADDRESS St. Joseph, Mo	25. DATE RECD. BY LOCAL REG. Jan. 8, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Hardell
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 Dr. Sharon E. Waggoner

1959, 1/12

JAN 12 1959

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 *Albert B. Harrington*

Licensed Embalmer No. *31551*

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.