

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001007

STATE FILE NUMBER

FILED FEB 9 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 124

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Springfield</b> <b>03460</b>
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>2204 E. Claiborne</b>		Length of stay in 1b <b>2 Yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>2204 E. Claiborne</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>MINNIE</b> Middle <b>BELLE</b> Last <b>PIERCE</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>2,</b> Year <b>1959</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 Sept. 1869</b>	9. AGE (In years last birthday) <b>89</b>	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) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Charles Loomis</b>	13b. MOTHER'S MAIDEN NAME <b>Martha Mendenhall</b>	14. NAME OF HUSBAND OR WIFE <b>Deceased</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT <b>Mrs. Robert Ream</b>	Address <b>Springfield, Mo.</b>
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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) <b>Cardiac Standstill</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>generalized arteriosclerosis</b>	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4330</b>		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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	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 <b>2/1/59</b> , to <b>2/2/59</b> and last saw her alive on <b>2/1/59</b> Death occurred <b>8:30</b> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>Thomas W. Souders MD</i> (Degree or title)	22b. ADDRESS <b>1211 S. Glenstone Springfield, Missouri</b>	22c. DATE SIGNED <b>2/4/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2-4-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Souders Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Near Humansville, Missouri</b>
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24. FUNERAL DIRECTOR <b>Beckwith Funeral Home</b>	ADDRESS <b>Humansville, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>2-5-59</b>	26. REGISTRAR'S SIGNATURE <i>Effie A. Melton</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

ALL INFORMATION ON THIS FORM MUST BE ACCURATELY STATED

MAR 18 1959

MAR 18 1959

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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 *Max Rhodes* .....

Licensed Embalmer No. *497* .....

P. O. Address *Springfield* .....

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.