Health, & Welfare Public Service

300
1-57 C

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-008484
STATE FILE NUMBER

FILED MAR 30 1958 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 307

1. PLACE OF DEATH
a. COUNTY: Buchanan
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): St. Joseph — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: Mo. Meth. Hospital — Length of stay in Hospital: 6 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Clinton
c. CITY OR TOWN: Gower — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Eugenia Middle: Last: Holmes

4. DATE OF DEATH: Month March Day 22 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: June 14, 1881
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher
10b. KIND OF BUSINESS OR INDUSTRY: School
11. BIRTHPLACE (City and state or country): Buchanan Co. Mo.
12. CITIZEN OF WHAT COUNTRY? USA.

13a. FATHER'S NAME: James W. Gibson
13b. MOTHER'S MAIDEN NAME: Nancy McCrary
14. NAME OF HUSBAND OR WIFE: Frank Holmes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Frank Holmes Address: Gower, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adynamic Paralytic Ileus — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Peptic Ulcer (Duodenal) with Hemorrhage — 8 days
DUE TO (c) 5410
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Masculinizing Tumor of Ovary 4-5 years
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 3-16-59, to 3-22-59 and last saw her alive on 3-22-59
Death occurred at 6:35 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: John P. Mabry (Degree or title) M.D.
22b. ADDRESS: Plattsburg, Mo.
22c. DATE SIGNED: 3-24-59

All diseases in Part I must be causally related.
Dr. John P. Mabrey
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 3/25/1959
23c. NAME OF CEMETERY OR CREMATORY: Allen Cemetery
23d. LOCATION (City, town, or county) (State): Gower Mo.

24. FUNERAL DIRECTOR: John H. Murray ADDRESS: Gower, Mo.
25. DATE RECD. BY LOCAL REG.: Mar 27, 1959
26. REGISTRAR'S SIGNATURE: Mrs Clark Yardell

(Licensed Embalmer's Statement on Reverse Side)

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 Me, Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed John H. Murray

Licensed Embalmer No. 2893

P. O. Address Gower 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.