

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013740

STATE FILE NUMBER

FILED APR 16 1959 Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 199

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jasper</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Joplin</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Sarasopie</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>General Hosp</u>			Length of stay in 1b <u>7 wks</u>			d. STREET ADDRESS <u>Mo</u> (If outside, give location)	
3. NAME OF DECEASED (Type or print) <u>Mary Belle Falls</u>				4. DATE OF DEATH <u>4-7-59</u>			
5. SEX <u>fe</u>		6. COLOR OR RACE <u>wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-10-1878</u>	
9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>			11. BIRTHPLACE (City and state or country) <u>Sarasopie Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Hazard</u>				14. MOTHER'S MAIDEN NAME <u>Betty Baker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <u>✓</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs Attie Knight</u> Address <u>cedar Ridge</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Circulatory Failure</u> Prolonged Remittent <u>recurrently</u> of <u>Progression of left stage, beyond feet</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>arteriosclerosis</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>55 days</u> <u>2 weeks</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			4501				
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 <u>6:40 a.m.</u> Month, Day, Year							
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>2-9-52</u> to <u>4-7-59</u> and last saw her ^{her} _{him} alive on <u>4-6-59</u> Death occurred at <u>6:40 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>H. Northstone M.D.</u>				22b. ADDRESS <u>Sarasopie Mo.</u>		22c. DATE SIGNED <u>4-7-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>4-9-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sarasopie Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Sarasopie Mo</u>	
24. FUNERAL DIRECTOR <u>Jackson Sons</u> ADDRESS <u>Sarasopie Mo</u>			25. DATE RECD. BY LOCAL REG. <u>4-13-1959</u>		26. REGISTRAR'S SIGNATURE <u>Noce Merriam</u>		

Health, Welfare Public Service

300 1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

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.....
Wm H Jackson

Licensed Embalmer No. *39*

P. O. Address *Savannah*

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.