

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-1921928
STATE FILE NUMBER

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 90

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only). OR TOWN <u>Webb City</u>		c. CITY OR TOWN <u>Joplin</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jane Chinn</u>		d. STREET ADDRESS (If outside, give location) <u>1508 West 26th</u>	
Length of stay in 1b <u>62 years</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Tivilla</u> Middle _____ Last <u>Stewart</u>			4. DATE OF DEATH <u>June 8, 1959</u> Month Day Year		
--	--	--	--	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>Nov. 13, 1868</u>	9. AGE (In years from birthday) <u>90</u>	10. F UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
----------------------	-------------------------------	---	---------------------------------------	---	---	--

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>Homemaking</u>	11. BIRTHPLACE (City and state or country) <u>Healertown, Penn.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	---	---	--

13a. FATHER'S NAME <u>Reubin Moll</u>	13b. MOTHER'S MAIDEN NAME <u>Elisabeth Weisel</u>	14. NAME OF HUSBAND OR WIFE <u>Charles Stewart</u>
---------------------------------------	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>491-04-4882F</u>	17. INFORMANT Address <u>Mrs. Mary Carroll Joplin, Missouri</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>TOXIC MYOCARDIOSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>METASTATIC CARCINOMA OF</u>		<u>2 yrs.</u>
	DUE TO (c) <u>THE SIGMOID, UTERUS, BLADDER</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>1992</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
---	--

20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m.
--

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 July 6, 1958 to June 8, 1959 and last saw her alive on June 8, 1959
Death occurred at 11:35 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>712 Florida</u>	22c. DATE SIGNED <u>6-9-59</u>
---	---------------------------------	--------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 10, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Joplin, Missouri</u>
---	--------------------------------	---	---

24. FUNERAL DIRECTOR <u>Thornhill-Dillon</u> ADDRESS <u>Joplin, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>6-16-59</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Madeline Switz</u>
--	---	--

All diseases in Part I must be causally related. H.B. Kerr-D.O.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

5. 300
1-57

~~MOUNN 23 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 *Robert C. Della*

Licensed Embalmer No. *5062*

P. O. Address *Joplin, 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.