

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-027527

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 389

FILED AUG 8 1962

VS 300  
Rev. 4/59

b499  
3499

3  
4 1  
5 2  
6  
7 0  
8 2

9592X

10  
11

1290-2

132-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

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>Joplin</u>		Length of stay in 1b <u>3 1/2 yrs</u>	c. CITY OR TOWN <u>Joplin</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2824 Missouri Ave</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2824 Missouri Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>GMMIE</u> Middle <u>L.</u> Last <u>LINDSEY</u>			4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1962</u>
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>2-24-1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE (last birthday) <u>83</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11a. FATHER'S NAME <u>G. B. Hackworth</u>		11b. MOTHER'S MAIDEN NAME <u>Mary Ware</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</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>none</u>	17. INFORMANT <u>Mrs. J.W. Pinkston, 2824 Missouri Ave</u> Address <u>Joplin, Mo</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>Hypostatic Pneumonia</u> DUE TO (b) <u>Uremia</u> DUE TO (c) <u>Chronic Glomerulo-nephritis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 dd.</u> <u>3 dd.</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized arteriosclerosis</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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.)	
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 <u>1960</u> to <u>7-28-62</u> and last saw her <u>alive</u> on <u>7-28-62</u> Death occurred at <u>7:50 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. E. Kelbaine M.D.</u>		22b. ADDRESS <u>408 W 4th, Joplin, Mo</u>	22c. DATE SIGNED <u>7-28-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>7-31-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Carthage, Mo</u>
24. FUNERAL DIRECTOR <u>KNELL MORTUARY Carthage, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>7-31-1962</u>	26. REGISTRAR'S SIGNATURE <u>Dora Merriam</u>

USE BLACK INK OR TYPEWRITER RIBBON

**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 Frank W. Kneel

Licensed Embalmer No. 4440

P. O. Address Carthage, 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.