

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-032609

STATE FILE NUMBER

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 433

DO NOT WRITE ON THIS STUB AMENDED

FILED SEP 11 1963

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>4 days</u>	c. CITY OR TOWN <u>Joplin, Missouri</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route 3 (6 Mile NW Joplin)</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY LEO HOLLINGSWORTH</u>			4. DATE OF DEATH Month Day Year <u>9-2-1963</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>12-5-1870</u>
9. AGE (last birthday) <u>92</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days 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>Home</u>	11. BIRTHPLACE (City and state or country) <u>Oklahoma</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>(unknown) Broomfield</u>	
13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Nate Hollingsworth (Dec'd)</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>[redacted]</u>	
17. INFORMANT <u>Richard Hollingsworth (Honeyoe Falls, Ark.)</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>Cerebral Thrombosis</u> ONSET AND DEATH <u>4 days</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) <u>Disruptio Militatis</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 a.m. p.m. 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>8-30-63</u> to <u>9-2-63</u> and last saw ^{her} _{him} alive on <u>9-2-63</u> . Death occurred at <u>11:45</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>E.B. Schaubel MD</u> (Degree or title)		22b. ADDRESS <u>Joplin Mo.</u>	22c. DATE SIGNED <u>9-3-63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-4-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Carl Junction Cemetery</u>	23d. LOCATION (City, town, or county) <u>Carl Junction, Missouri</u>
24. FUNERAL DIRECTOR <u>Roney Funeral Service, Carl Jct, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>9-9-1963</u>	26. REGISTRAR'S SIGNATURE <u>Dore Merriam</u>

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	DATE AMENDED	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ
Rev. 4/59								
<u>10499</u>								
<u>20490</u>								
<u>3</u>								
<u>4 1</u>								
<u>5 2</u>								
<u>6</u>								
<u>7 1</u>								
<u>8 2</u>								
<u>9 332X</u>								
<u>10</u>								
<u>11</u>								
<u>12 3-0</u>								
<u>13 2-0</u>								

USE BLACK INK OR TYPEWRITER RIBBON

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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 Jack C Simpson

Licensed Embalmer No. 4647

P. O. Address Webb City, 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.