

Duplicate of  
 health,  
 Welfare  
 Public  
 service  
  
 300  
 1-56  
  
 All  
 diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 2027

FILED JAN 31 1957 Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 36

1. PLACE OF DEATH a. COUNTY <b>Marion</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Marion</b>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Palmyra</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Elizabeth</b>			Length of stay in lb		d. STREET ADDRESS <b>715 S. Main</b>			Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Golda M. Stoneham</b>				First	Middle	Last	4. DATE OF DEATH <b>1-12-1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/19/1883</b>		9. AGE (In years last birthday) <b>73</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Hannibal, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>J. C. McElhiney</b>				14. MOTHER'S MAIDEN NAME <b>Anna Menieare</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Catherine Juetta, Palmyra, Mo.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis Generalized</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Carcinoma of left breast</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) <b>170X</b>								INTERVAL BETWEEN ONSET AND DEATH <b>4-5 years</b>  <b>2-3 years</b>		
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.										
20d. INJURY OCCURRED WHILE AT <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 <b>1/8/57</b> to <b>1/12/57</b> and last saw her alive on <b>1/12/57</b> Death occurred at <b>7:00A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <b>J. W. Well, M.D.</b> (Degree or title)				22b. ADDRESS <b>Palmyra Mo.</b>			22c. DATE SIGNED <b>1/22/57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)					
<b>Burial</b>		<b>1/15/57</b>	<b>Mt. Olivet Cemetery</b>		<b>Hannibal, Mo.</b>					
24. FUNERAL DIRECTOR <b>J. M. McDonnell</b> ADDRESS <b>Hannibal, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>1-24-57</b>		26. REGISTRAR'S SIGNATURE <b>Mr. E. M. Lucke</b>					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

RECEIVED JAN 29 1957

MARION CO. HEALTH DEPT.

DATE FILED JAN 23 1957

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 .....

*H. M. O'Donnell*

Licensed Embalmer No. 388

P. O. Address Hannibal.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.