

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3018

FILED MAR 4 1957

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 203

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Joseph</u> <u>0117</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>State Hospital #2</u>		Length of stay in lb <u>Most of life</u>		d. STREET ADDRESS <u>307 S. 13th St.</u> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u></u> Last <u>Stigall</u>				4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>1957</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>November 29, 1866</u>		9. AGE (In years last birthday) <u>90</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></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>at home</u>		11. BIRTHPLACE (City and state or country) <u>St. Joseph, Missouri.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Sebron Jones Holman</u>				14. MOTHER'S MAIDEN NAME <u>Amanda B. Burnett</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>Louis V. Stigall</u>		Address <u>St. Joseph, 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>Myocarditis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Chronic</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>Arterio sclerosis</u>		
						DUE TO (c) <u></u>		
PART II. OTHER SIGNIKANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I((n)						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.) <u>4221</u>					
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a. m. <u></u> p. m. <u></u>								
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 <u>St. Joseph</u>		COUNTY <u>Buchanan</u> STATE <u>Missouri</u>		
21. I attended the deceased from <u>2-26, 1957</u> to <u>2-26, 1957</u> and last saw her ^{father} alive on <u>2-26-57</u> . Death occurred at <u>4:25 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>G. E. Gossine M.D.</u>				22b. ADDRESS <u>State Hospital #2 St. Joseph, Mo.</u>		22c. DATE SIGNED <u>2-26-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Feb. 28, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Mora Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Meierhoffer-Fleeman, Inc., St. Joseph, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Feb. 28, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Cather M. Allison</u>		

(Licensed Embalmer's Statement on Reverse Side)

health, welfare, public service
 300 -56
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be stated. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Albert D. ...*

Licensed Embalmer No. 3258

P. O. Address St. Joseph

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