

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-018253  
STATE FILE NUMBER

FILED JUN 5 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2404

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>Saline</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>MARSHALL 097<sup>2</sup></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>V.A. Hospital</b>		Length of stay in 1b <b>59 days</b>	d. STREET ADDRESS (If outside, give location) <b>169 W. Washington</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ELMER</b> Middle <b>B.</b> Last <b>HERGINS</b>			4. DATE OF DEATH Month <b>5th</b> Day <b>10th</b> Year <b>1958</b>		
5. SEX <b>2</b> <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-7-96</b>	9. AGE (In years last birthday) <b>62 yrs</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	11. BIRTHPLACE (City and state or country) <b>Blackwater, Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Smith Hergins</b>		13b. MOTHER'S MAIDEN NAME <b>Belle Banks</b>		14. NAME OF HUSBAND OR WIFE <b>Maggie Hergins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WWI</b>		16. SOCIAL SECURITY NO. <b>495-07-2225</b>	17. INFORMANT Address <b>V.A. Hospital Records, Kansas City, 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>Inanition</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1621</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Bronchogenic carcinoma, left lung, with extensive</b> DUE TO (c) <b>pulmonary suppurative disease and emphyema</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					
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 <input type="checkbox"/> NOT WHILE WORKING <input checked="" type="checkbox"/> 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. <input checked="" type="checkbox"/> attended the deceased from <b>March 2, 1958</b> to <b>May 10, 1958</b> Death occurred at <b>11:15 a</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>A. Williams</b> (Degree or title) <b>MD</b>			22b. ADDRESS <b>V.A. Hospital, K.C., Mo</b>		22c. DATE SIGNED <b>5-11-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>5-14-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Nelson</b>		23d. LOCATION (City, town, or county) (State) <b>Saline Co. Missouri</b>
24. FUNERAL DIRECTOR <b>George H. Green Marshall</b> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <b>5-12-58</b>	26. REGISTRAR'S SIGNATURE <b>neva minshall</b>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

**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 *Raymond Green*

Licensed Embalmer No. 4220

P. O. Address Needell, 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.