Dr. McDaniel

FILED FEB 27 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-006573

STATE FILE NUMBER

Registration District No. 272 Primary Registration District No. 5908 Registrar's No. 16

1. PLACE OF DEATH
a. COUNTY Pemiscot
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN West Hermondale — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION Holland Pay — Length of stay in 1b 35 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Pemiscot
c. CITY OR TOWN West Hermondale 0780 — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS Holland Pay (If outside, give location) — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First Effie Middle Lee Last Stubbs

4. DATE OF DEATH Month Day Year 2-2-59

5. SEX F 3

6. COLOR OR RACE Cal

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 1-27-1883

9. AGE (In years last birthday) 76 — 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) Home Work

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Miss

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Charley Barrow

13b. MOTHER'S MAIDEN NAME unknown

14. NAME OF HUSBAND OR WIFE Sail Stubbs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Zeala Webb — Address St Louis Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma rt. breast c general metastasis

INTERVAL BETWEEN ONSET AND DEATH 1 year

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) 170X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ 0

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 10-15-58, to 2-2-59 and last saw her/him alive on 2-1-59
Death occurred at ____ a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H L McDaniel MD

22b. ADDRESS Steele Mo

22c. DATE SIGNED 2-6-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 2-8-59

23c. NAME OF CEMETERY OR CREMATORY Oak Grove

23d. LOCATION (City, town, or county) Holland (State) MO

24. FUNERAL DIRECTOR Berman Funeral Home Steele — ADDRESS

25. DATE RECD. BY LOCAL REG. 2/14/59

26. REGISTRAR'S SIGNATURE L L O'Rennan

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MAR 20 1959

CARUTHERSVILLE, MO.

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 ..... Signed .....
Signature of Student Embalmer

Licensed Embalmer No. 3941

P. O. Address Caruthersville

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.