

STANDARD CERTIFICATE OF DEATH

 BIRTH NO. 27822-49 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 692

1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Greene			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fair Grove Jackson Twp		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital				3. NAME OF DECEASED a. (First) Jerry b. (Middle) DuVal c. (Last) Coursey			
4. DATE OF DEATH (Month) (Day) (Year) Aug 4 1949		5. SEX M.		6. COLOR OR RACE W.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	
8. DATE OF BIRTH June 1-1949		9. AGE (In years last birthday) 2 1/4		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Mo. Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Herman D. Coursey		13b. MOTHER'S MAIDEN NAME Garrett Hooney	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Herman Coursey (Father) ADDRESS Fair Grove, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Meningitis INTERVAL BETWEEN ONSET AND DEATH 7 days ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. draining right ear				ADDITIONAL SUPPLEMENTARY INFORMATION AUTOPSY? REQUESTED YES <input type="checkbox"/> NO <input type="checkbox"/>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) Springfield, Greene, Mo		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR					
22. I hereby certify that I attended the deceased from ^{10:20 P.M.} 8-4-49 , 19 ^{10:15 P.M.} 8-4- , 1949, that I last saw the deceased alive on 8-4-49 , 19, and that death occurred at 11:00 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE Paul J. Busiek M.D. (Degree or title)				23b. ADDRESS 1635 E. Walnut St.		23c. DATE SIGNED 8-4-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug. 7, 1949		24c. NAME OF CEMETERY OR CREMATORY Bassville Cemetery		24d. LOCATION (City, town, or county) (State) Near Fair Grove, Mo.	
DATE REC'D BY LOCAL REG. 8-5-49		REGISTRAR'S SIGNATURE W.S. Handley		25. FUNERAL DIRECTOR'S SIGNATURE Palma Schmeizer ADDRESS B. 302		J. H. Springfield, 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
Student Embalmer

Signed _____

Licensed Embalmer No. 4562

P. O. Address Springfield, Vt.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.