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FILED AUG 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Kelly
23168
State File No. _____
Registrar's No. 673

128

5465

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____	
1. PLACE OF DEATH a. COUNTY Greene			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN (Rural) N. Campbell Twp		c. LENGTH OF STAY (in this place) 1 Wk	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN (Rural) N. Campbell Township		
d. FULL NAME OF HOSPITAL OR INSTITUTION Greene County Farm			d. STREET ADDRESS (If rural, give location) Greene County Farm		
3. NAME OF DECEASED (Type or Print) a. (First) James		b. (Middle) ---	c. (Last) Hurst	4. DATE OF DEATH (Month) (Day) (Year) July 29, 1949	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Unknown	8. DATE OF BIRTH Unknown	9. AGE (in years last birthday) unknown	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown	10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME ADDRESS County Farm Records, Springfield,			
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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Ruptured blood vessel</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 331X
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE (Specify) HOMICIDE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
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 <u>1-19</u> , 1949, to <u>7-29</u> , 1949, that I last saw the deceased alive on <u>7-14</u> , 1949, and that death occurred at <u>1:10</u> a.m., from the causes and on the date stated above.					
23a. SIGNATURE <u>W. Kelly MD</u> (Degree or title)			23b. ADDRESS <u>Springfield, Mo</u>		23c. DATE SIGNED <u>7-29-49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE <u>7/30/49</u>	24c. NAME OF CEMETERY OR CREMATORY Hazelwood	24d. LOCATION (City, town, or county) (State) Springfield, Mo.		
DATE REC'D BY LOCAL REG. <u>7-30-49</u>	REGISTRAR'S SIGNATURE <u>W. J. Handley MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H.H. Lohmeyer 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.

Signed Walter E. Hamilton

Signed.....
Student Embalmer

Licensed Embalmer No. 3808

P. O. Address Springfield, 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 this body is not embalmed, fact should be so stated above.