

FILED NOV 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36937**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **1013**

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 Springfield,		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	
c. LENGTH OF STAY (in this place) 11 days		d. STREET ADDRESS (If rural, give location) 1006 North National	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Marion	b. (Middle) A.	c. (Last) Preston	4. DATE OF DEATH (Month) (Day) (Year) November 19 1949
-------------------------------------	--------------------------	-----------------------	--------------------------	---

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 30, 1884	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Days	Hours	Min.
--------------------	-------------------------------	---	---------------------------------------	---	------------------------	----------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Dealer	10b. KIND OF BUSINESS OR INDUSTRY Used cars business	11. BIRTHPLACE (State or foreign country) Hogersville, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	--	--

13a. FATHER'S NAME William H Preston	13b. MOTHER'S MAIDEN NAME Paralee Tillman	14. NAME OF HUSBAND OR WIFE Iva O. Preston
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Mrs Iva O. Preston, Springfield, Missouri	ADDRESS
---	--	--	---------

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction		11 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Arteriosclerotic Coronary Thrombosis		11 days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			4-21

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

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)
--	--	---

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 **Oct 1, 1949, to Nov 19, 1949**, that I last saw the deceased alive on **Nov 19, 1949**, and that death occurred at **10:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Kenneth C. Coffey M.D.	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 11-19-49
---	--------------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov 22, 1949	24c. NAME OF CEMETERY OR CREMATORY Greenlawn	24d. LOCATION (City, town, or county) (State) Springfield, Missouri
---	-------------------------------	---	--

DATE REC'D BY LOCAL REG. 11-21-49	REGISTRAR'S SIGNATURE W. G. Handley, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Alma Schmeyer	ADDRESS Springfield, Mo.
--	--	---	---------------------------------

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

39
2
6

39
2
6
0

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 Bernard F. Wright

Licensed Embalmer No. 4293

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.