

FILED SEP 18 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 30023

814

0396
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BIRTH NO. _____		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 2000		Registrar's 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 OR TOWN Springfield		c. LENGTH OF STAY (In this place) 9 hours		c. CITY (If outside corporate limits, write RURAL and give township) Springfield		0397 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital				d. STREET ADDRESS (If rural, give location) 831 S. Pickwick			
3. NAME OF DECEASED a. (First) John b. (Middle) Levi c. (Last) Maynard			4. DATE OF DEATH (Month) (Day) (Year) Sept. 14 1950				
5. SEX Male 0		COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 1		8. DATE OF BIRTH Sept. 3 - 1888	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Division Engineer		10b. KIND OF BUSINESS OR INDUSTRY State Highway		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Herbert Maynard			13b. MOTHER'S MAIDEN NAME Elizabeth Taylor			14. NAME OF HUSBAND OR WIFE Ethel Maynard	
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. Ethel Maynard ADDRESS 831 S. Pickwick			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u> INTERVAL BETWEEN ONSET AND DEATH <u>9 1/2 hours</u>							
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? first saw him 1:00 PM - Sept. 14 - 50			
22. I hereby certify that I attended the deceased from 9-14 , 1950, to 9-14 , 1950, that I last saw the deceased alive on 9-14 , 1950, and that death occurred at 4:40 P. m. , from the causes and on the date stated above.							
23a. SIGNATURE Amurick mo (Degree or title)				23b. ADDRESS Springfield, Mo.		23c. DATE SIGNED 9-14-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Sept 15, 1950		24c. NAME OF CEMETERY OF CREMATORY Unknown		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
DATE REC'D BY LOCAL REG. 9-16-50		REGISTRAR'S SIGNATURE W.E. Handley		25. FUNERAL DIRECTOR'S SIGNATURE Gorman-Scharpf Funeral Home ADDRESS Springfield, Missouri			

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

SEP 29 1950

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 *Lewis G. Scherpf* _____

Licensed Embalmer No. *38078* _____

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.