

FILED NOV 29 1950

STANDARD CERTIFICATE OF DEATH

State File No. 36778
Registrar's No. 1017-D

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5462

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 rural, specify, write RURAL and give township) Springfield OR TOWN Rural Franklin Township		c. CITY (If rural, specify, write RURAL and give township) Springfield 0390 OR TOWN Rural Franklin Township 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route # 1 Springfield, Mo.		d. STREET ADDRESS (If rural, give location) Route # 1 Springfield, Mo.	

3. NAME OF DECEASED (Type or Print) a. (First) HARRY b. (Middle) TURNER c. (Last) STEINBECK			4. DATE OF DEATH (Month) (Day) (Year) Nov. 16, 1950			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 12, 1878	9. AGE (in years last birthday) 72	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) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Mendon, Missouri		12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Joseph Steinbeck	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Stella Steinbeck
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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 Arnold Steinbeck, Springfield, Mo.	ADDRESS Springfield, Mo.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 157X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Pancreas & Liver -		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Rectal ulcer			

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

22. I hereby certify that I attended the deceased from **July, 1945, to Nov. 16, 1950**, that I last saw the deceased alive on _____, 19____, and that death occurred at **8:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Paul O. Upshaw, M.D.	(Degree or title)	23b. ADDRESS Springfield, Missouri	23c. DATE SIGNED 11-18-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/18/50	24c. NAME OF CEMETERY OR CREMATORY Greenlawn	24d. LOCATION (City, town, or county) (State) Springfield, Mo.
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DATE REC'D BY LOCAL REG. 11-20-50	REGISTRAR'S SIGNATURE W E Handley	25. FUNERAL DIRECTOR'S SIGNATURE H. H. Lohmeyer	ADDRESS Springfield, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Levin T. Swadley

Licensed Embalmer No. 4815

P. O. Address Springfield

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.