No. 300
10.46

0396

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12585

MAY 12 1952

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 443

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Springfield,
c. LENGTH OF STAY (In this place): 6 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Laclede
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Phillipsburg 0530
d. STREET ADDRESS (If rural, give location): /

3. NAME OF DECEASED (Type or Print)
a. (First): Samuel
b. (Middle): C.
c. (Last): Caffey

4. DATE OF DEATH (Month) (Day) (Year): May 3, 1952

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: October 25, 1887
9. AGE (In years last birthday): 64 — 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: Farming
11. BIRTHPLACE (City and State or Foreign Country): Webester County, Missouri 0
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Joseph Caffey
13b. MOTHER'S MAIDEN NAME: Mary Gass
14. NAME OF HUSBAND OR WIFE: — — — — — —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S SIGNATURE OR NAME — ADDRESS: VA Hospital Records, Springfield, Missouri

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Right Cerebral Infarction

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Advanced arteriosclerosis with ulcerations and thrombosis.
DUE TO (c) Advanced coronary sclerosis.
DUE TO (c) Atelectasis pulmonary infarctions.

INTERVAL BETWEEN ONSET AND 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 4301
20. AUTOPSY? YES [X] NO [ ]

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 [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 28, 19 52 *to* May 3, 19 52 *that I last saw the deceased alive on* XXXXXXXXXXXXXXXXXXXX *and that death occurred at* 3:50 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE A. J. Bondurant M.D. (Degree or title)
A. J. Bondurant M.D. Chief of Professional Services
23b. ADDRESS VA Hospital Springfield, Mo
23c. DATE SIGNED May 3, 1952

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: May 6, 1952
24c. NAME OF CEMETERY OR CREMATORY: Unknown
24d. LOCATION (City, town, or county) (State): Lebanon, Mo

DATE REC'D BY LOCAL REG.: 5-5-52
REGISTRAR'S SIGNATURE: James R. Lowe M.D.
25. FUNERAL DIRECTOR'S SIGNATURE — **ADDRESS**: Alma Lohmeyer, Springfield, Mo
(Licensed Embalmer's Statement on Reverse Side)

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. 4939

P. O. Address _____

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.