

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Schwartz
State File No. 16086

No. 300
10.48

FILED MAY 19 1952

BIRTH NO. 28526 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 480

395
0

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

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	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL		d. STREET ADDRESS (If rural, give location) 1638 E. LOMBARD	
3. NAME OF DECEASED (Type or Print) a. (First) INFANT		b. (Middle) KLINKER	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) MAY 14, 1952	
5. SEX MALE 0	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) INFANT 0	8. DATE OF BIRTH MAY 12, 1952
9. AGE (In years last birthday) - - -		10. KIND OF BUSINESS OR INDUSTRY * * * *	11. BIRTHPLACE (City and State or Foreign Country) SPRINGFIELD, MO. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) * * * *		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME RALPH KLINKER		13b. MOTHER'S MAIDEN NAME MARGARET ROBINSON	
14. NAME OF HUSBAND OR WIFE * * * *		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME FATHER—RALPH KLINKER, 1638 E. LOMBARD	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity - 26 wks. gestation Birth wt. 3 lbs. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 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 776x	
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)		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 May 12, 1952, to May 14, 1952, that I last saw the deceased alive on May 14, 1952, and that death occurred at 5 P. M., from the causes and on the date stated above.			
23a. SIGNATURE J. Schwartz M.D.		23b. ADDRESS 609 Cherry, Springfield, Mo.	
23c. DATE SIGNED 5-16-52		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE May 17, 1952		24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	
24d. LOCATION (City, town, or county) (State) Springfield, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Herman H. Lohmeyer, Springfield	
DATE REC'D BY LOCAL REG. 5-17-52		REGISTRAR'S SIGNATURE James H. Amos MLE	

STATEMENT BY LICENSED EMBALMER

(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 *James T. Luskley*

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.