

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34716

State File No. \_\_\_\_\_

NOV 10 1952

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>985</u>			
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
a. COUNTY Greene		b. CITY (If outside corporate limits, write RURAL and give township) Springfield		a. STATE Missouri		b. COUNTY Greene			
c. LENGTH OF STAY (In this place) 17 days		c. CITY (If outside corporate limits, write RURAL and give township) Springfield		d. STREET ADDRESS (If rural, give location) 927 East Monroe					
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital				4. DATE OF DEATH November 2 1952					
3. NAME OF DECEASED (Type or Print)		a. (First) WILLIAM		b. (Middle) BENJAMIN		c. (Last) SHULTZ			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH August 5, 1883			
9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Public Schools		11. BIRTHPLACE (City and State or Foreign Country) Springfield, Missouri			
11. BIRTHPLACE (City and State or Foreign Country) Springfield, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Billy Shultz		13b. MOTHER'S MAIDEN NAME Unknown			
13a. FATHER'S NAME Billy Shultz		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Mrs Bessie Shultz		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Mrs Bessie Shultz, Springfield, Mo.		ADDRESS Mrs Bessie Shultz, Springfield, Mo.			
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				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive Heart Failure</u>				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u>				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	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)			
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)			
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 <u>8-23-</u> <u>1952</u> , to <u>11-2-</u> <u>1952</u> , that I last saw the deceased alive on <u>11-2-</u> <u>1952</u> , and that death occurred at <u>5:32P</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <u>Harold H. Lurie, M.D.</u> (Degree or title)				23b. ADDRESS <u>Medical Arts Bldg. Springfield, Mo.</u>		23c. DATE SIGNED <u>11-4-52</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Nov 4, 1952		24c. NAME OF CEMETERY OR CREMATORY Maple Park Cemetery		24d. LOCATION (City, town, or county) (State) Springfield, Missouri			
DATE REC'D BY LOCAL REG. <u>11-4-52</u>		REGISTRAR'S SIGNATURE <u>Edith Williamson Registrar</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph E. Windle</u>		ADDRESS <u>Springfield, Mo.</u>			

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

write  
med arts

**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 James W. Wair

Licensed Embalmer No. 4650

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.