

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9386**

FILED MAR 23 1953

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 285

1396
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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 City Hospital		d. STREET ADDRESS (If rural, give location) 906 Woodlawn	

3. NAME OF DECEASED (Type or Print) a. (First) MARY	b. (Middle)	c. (Last) BATES	4. DATE OF DEATH (Month) (Day) (Year) March 17 1953
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 31 July 1866	9. AGE (In years) (Month) (Day) (Hour) (Min.) 86
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY In home	11. BIRTHPLACE (State or foreign country) Ohio	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Smiley Ware	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Deceased
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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. No	17. INFORMANT'S SIGNATURE OR NAME Fay Kidd 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, ashenia, 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) Cerebral Hemorrhages		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis generalized 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	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)
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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?
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22. I hereby certify that I attended the deceased from 3-12, 1953 to 3-17, 1953, that I last saw the deceased alive on 3-17-53, 1953, and that death occurred at 12:15 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Stanley A. Peterson M.D.	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 3-19-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-19-53	24c. NAME OF CEMETERY OR CREMATORY Hazelwood Cemetery	24d. LOCATION (City, town, or county) (State) Springfield, Mo.
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DATE REC'D BY LOCAL REG. 3-20-53	REGISTRAR'S SIGNATURE Edith Williams Registrar	25. FUNERAL DIRECTOR'S SIGNATURE J. W. KLINGNER & CO. ADDRESS Springfield, Mo.
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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 *J. B. Klingman* _____

Licensed Embalmer No. *3358* _____

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.