

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **9460**

No. 300
10-48

FILED MAR 30 1953
BIRTH RD. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 302

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 0396	
d. FULL NAME OF HOSPITAL OR INSTITUTION 805 Fullbright Avenue		d. STREET ADDRESS (If rural, give location) 805 Fullbright Avenue 0	
3. NAME OF DECEASED (Type or Print) ELIZABETH		4. DATE OF DEATH (Month) (Day) (Year) March 22, 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 6, 1901
9. AGE (In years last birthday) 51		10. MONTHS 5	11. DAYS 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) 0
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME William Hickman	
13b. MOTHER'S MAIDEN NAME Ella E. Smith		14. NAME OF HUSBAND OR WIFE Thomas N. Marcum	
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. W. S. Ringenburg/Springfield, Mo.		ADDRESS	
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.		<p align="center">MEDICAL CERTIFICATION</p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute pulmonary edema ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic myocardial insufficiency 2 yr 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 4222	
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) m.	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 5-21 , 19 50 , to 3-21 , 19 53 , that I last saw the deceased alive on 3-21 , 19 53 , and that death occurred at 6:30 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Blondine M. ...		23b. ADDRESS Springfield, Missouri	23c. DATE SIGNED 3/23/53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/26/53	24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	24d. LOCATION (City, town, or county) (State) Springfield, Mo.
DATE REC'D BY LOCAL REG. 3-24-53	REGISTRAR'S SIGNATURE Edith Williamson Ref.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS AYRE-GOODWIN FUN'L SERVICE, Spg'fld, Mo.,	

NOV 6 1958

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 Harry C. [Signature]

Licensed Embalmer No. 4594

P. O. Address Springfield, Missouri

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.