

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17671

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

FILED MAY 25 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **469-A**

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE <b>Mo</b> b. COUNTY <b>Night</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Springfield</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>MT. GROVE 1141</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Springfield Baptist Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>/</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Ida</b> b. (Middle) <b>M</b> c. (Last) <b>Foxworthy</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>5-13-53</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>May 1 - 1874</b>	9. AGE (In years last birthday) <b>79</b>	10. IF UNDER 1 YEAR Days <b>0</b> Hours <b>12</b> IF UNDER 12 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Boston, Mass</b>	
12a. FATHER'S NAME <b>Charles Lincoln</b>			13b. MOTHER'S MAIDEN NAME <b>Etha Johnson</b>		14. NAME OF HUSBAND OR WIFE <b>-</b>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>no</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Hazel Martin, daughter, Mt. Grove Mo</b>		ADDRESS <b>Mo 2</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH <b>one hr.</b>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic heart disease</b>			<b>several years</b>
		DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Fracture, intertrochanteric Femur, rt.</b>			<b>MAY 8, 1953</b>

19a. DATE OF OPERATION <b>MAY 9, 1953</b>	19b. MAJOR FINDINGS OF OPERATION <b>Fracture as noted #11.</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>4200 F</b>	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>MAY 8, 1953 noon</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Fell at home</b>
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22. I hereby certify that I attended the deceased from **MAY 8, 1953**, to **MAY 13, 1953**, that I last saw the deceased alive on **5-13, 1953**, and that death occurred at **3:30 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Frank Lundstrom M.D.</b>		23b. ADDRESS <b>205 St. Louis St. Springfield, Mo</b>		23c. DATE SIGNED <b>5-18-53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>5-13-53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Mt. Grove Mo</b>	
DATE REC'D BY LOCAL REG. <b>5-19-53</b>	REGISTRAR'S SIGNATURE <b>Edith Williams</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Frank Wendt</b> ADDRESS <b>Mt. Zion</b>		

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

1956 JUL 20 1953

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.....

*Frank Gable*

Licensed Embalmer No. ....

*448*

P. O. Address.....

*Inter River*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.