

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 927

FILED FEB 1 1954

BIRTH NO. REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 104

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) Springfield		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN Springfield
d. FULL NAME OF HOSPITAL OR INSTITUTION: 2405 N. Elizabeth		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS: 2405 N. Elizabeth		(If rural, give location) 0396	
3. NAME OF DECEASED (Type or Print)	a. (First) LYDIA	b. (Middle) M.	c. (Last) HAVILAND
4. DATE OF DEATH January 28, 1954		5. SEX Female	
6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 17 Oct. 1869	9. AGE (In years last birthday) 84
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 (City and State or Foreign Country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME John P. Huffman	13b. MOTHER'S MAIDEN NAME Catherine Reed	14. NAME OF HUSBAND OR WIFE Deceased	
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 W.M. Stubblefield ADDRESS 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) Cerebral Arteriosclerosis		2 yrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia		3 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 334 X	20. AUTOPSY YES <input type="checkbox"/> NO <input 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 **May 1953** to **Jan 28, 1954**, that I last saw the deceased alive on **Jan 23, 1954**, and that death occurred at **7:05 P.m.** from the causes and on the date stated above.

23a. SIGNATURE James T. Good M.D.	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 1-29-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-30-54	24c. NAME OF CEMETERY OR CREMATORY Delaware Cemetery
24d. LOCATION (City, town, or county) (State) Birch Tree, Missouri	25. FUNERAL DIRECTOR'S SIGNATURE J.W. KLINGNER & CO. ADDRESS Springfield, Mo	

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

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Ogle Stone Jr.*

Licensed Embalmer No. *412*

P. O. Address *Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.