

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **11776**

BIRTH NO. **FILED APR 26 1954** REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **400**

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Springfield</b>		c. LENGTH OF STAY (in this place) <b>40 yrs.</b>	c. CITY OR TOWN <b>Springfield</b> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Johns Hospital.</b>		e. STREET ADDRESS (If rural, give location) <b>1015 Sherman St.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>CLINTON</b> b. (Middle) <b>MASSINGALE</b> c. (Last) <b>MASSINGALE</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>4 19 54</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>2 29 79</b>	9. AGE (in years last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days	IF UNDER 10 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Clinton Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>James Massingale</b>		13b. MOTHER'S MAIDEN NAME <b>unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Lucille Massingale</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Lucille Massingale 1015 Sherman</b>	

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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <b>Respiratory thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <b>Prostatic Hypertrophy</b>		DUE TO (c)	
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 <b>4-13-54</b>		19b. MAJOR FINDINGS OF OPERATION <b>Prostatic Hypertrophy 610X</b>		20. AUTOPSY? YES <input checked="" 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)		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 **4-13, 1954**, to **4-19, 1954**, that I last saw the deceased alive on **4-18, 1954**, and that death occurred at **8:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>H. T. Smith</b>		23b. ADDRESS <b>602 N. Jefferson</b>		23c. DATE SIGNED <b>4-20-54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>4 22 54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Hazelwood Cemetery</b>	
		24d. LOCATION (City, town, or county) <b>Springfield</b>		(State) <b>Mo.</b>	

DATE REC'D BY LOCAL REG. <b>4-22-54</b>		REGISTRAR'S SIGNATURE <b>Edith Williamson</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>H. T. Smith 602 N. Jefferson</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAR 26 1935  
MAR 28 1935

MAR 3

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.....  
Signature of Student Embalmer

Signed *Herbert Y. Smith*

Licensed Embalmer No. *428*

P. O. Address *Springfield*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.