

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33611

State File No. _____

FILED NOV 8 - 1954

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 1006

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>18 months</u>	c. CITY OR TOWN <u>Springfield</u> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Devine Nursing Home</u>		e. STREET ADDRESS (If rural, give location) <u>1038 E. Division</u> <u>0396</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Hazie</u> b. (Middle) <u>Killingsworth</u> c. (Last) <u>Jordan</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 31</u> <u>1954</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>August 22-1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (In years last birthday) <u>75</u> If under 1 year: Months _____ Days _____ Hours _____ Min. _____
13a. FATHER'S NAME <u>John Rice Killingsworth</u>		13b. MOTHER'S MAIDEN NAME <u>Gent</u>	14. NAME OF HUSBAND OR WIFE <u>Peter Jordan</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME (and address) <u>Mrs. Alvin Grim - Springfield, Mo.</u>

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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		<u>?</u>
ANTECEDENT CAUSES		DUE TO (b) <u>Arteriosclerosis Heart Disease</u> <u>10-7 days</u>	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS		<u>Generalized Arteriosclerosis?</u>	
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? <u>4200</u> 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) _____	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 10-6, 1954 to OCT. 31, 1954 that I last saw the deceased alive on 10-6, 1954 and that death occurred at 7:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>David A. Hall, MD</u>		23b. ADDRESS <u>1951 South 90th</u>		23c. DATE SIGNED <u>11/3/54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Nov. 3-1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Robberson Prairie Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>GREENE Co., MO</u>	
DATE REC'D BY LOCAL REG. <u>11-4-54</u>	REGISTRAR'S SIGNATURE <u>South Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Gunning</u> ADDRESS <u>Sp 19 200</u>		

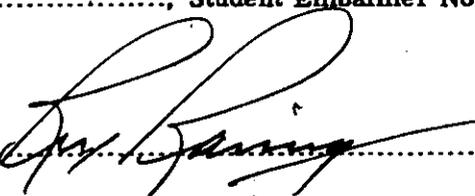
(Licensed Embalmer's Statement on Reverse Side)

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 embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision..

Student _____
Signature of Student Embalmer

Signed  _____
Licensed Embalmer No. 33

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