

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4513

State File No.

FILED MAR 14 1955

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 208

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) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>3 weeks</u>	c. CITY OR TOWN <u>Springfield</u>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Burge Hospital</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		* STREET ADDRESS (If rural, give location) <u>1006 West Walnut</u> <u>0396</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>VIRGINIA</u> b. (Middle) <u>MC QUIGG</u> c. (Last) <u>JONES</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 7 1955</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>April 8, 1861</u>	9. AGE (In years last birthday) <u>93</u>	IF UNDER 1 YEAR Months _____ Days _____
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>Own Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Greene Co., Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>John W McQuigg</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Robertson</u>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>J. W. Jones, Springfield, Missouri</u>	ADDRESS _____
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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, ashenia, 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>Hypertensive cardiovascular disease</u>		<u>15 yrs.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <u>443 X</u>
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 Sept. 3, 1954, to Mar. 7, 1955, that I last saw the deceased alive on March 7, 1955, and that death occurred at 2:05P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Leslie B. Webb Omd.</u>	23b. ADDRESS <u>609 Cherry, Springfield, Mo.</u>	23c. DATE SIGNED <u>3/8/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>March 9, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Clear Creek Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Near Springfield, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>3-8-55</u>	REGISTRAR'S SIGNATURE <u>Edna Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Schmeyer, Springfield, Mo.</u>	ADDRESS <u>R.W.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Webb
Pres

NOV 28 1962

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 *Robert E. Mulhman*

Licensed Embalmer No. *4916*

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.