

Jr. Hall

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7815

State File No.

FILED APR 4 1955

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 271

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) OR TOWN Springfield		c. CITY OR TOWN Fair Grove	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: City Hospital		e. STREET ADDRESS (If rural, give location) RED#2	

3. NAME OF DECEASED (Type or Print)	a. (First) CHARLES	b. (Middle) EDWARD	c. (Last) DAY	4. DATE OF DEATH (Month) (Day) (Year) March 24, 1955
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12 Feb. 1868	9. AGE (In years last birthday) 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and State or Foreign Country) Iowa	12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Andrew J. Day	13b. MOTHER'S MAIDEN NAME Elsie Jane Hixonbaugh	14. NAME OF HUSBAND OR WIFE Nancy L. Day
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Nancy L. Day Fair Grove, 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) Adenocarcinoma of Prostate		
	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"/>
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) 177X

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?
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22. I hereby certify that I attended the deceased from 2/25/55 to 3/24/55, that I last saw the deceased alive on 3/24/55 and that death occurred at 1:25P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) David J. Hall M.D.	23b. ADDRESS 1951 S. National Springfield, Missouri	23c. DATE SIGNED 3-28-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-27-55	24c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery
DATE REC'D BY LOCAL REG. 3-28-55		24d. LOCATION (City, town, or county) (State) Dallas County, Missouri

REGISTRAR'S SIGNATURE Edith Williams	FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. Klingner 16 Springfield, Mo.
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(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 *Glen D. Williams*

Licensed Embalmer No. *4651*

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.