

FILED AUG 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25802

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>725</u>	
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 OR TOWN <u>SPRINGFIELD</u>		c. LENGTH OF STAY (in this place)		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>BURGE HOSPITAL</u>				e. STREET ADDRESS (If rural, give location) <u>1043 E. BLAINE</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ARTHUR</u>		b. (Middle) <u>E.</u>		c. (Last) <u>CASH</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>AUG. 18, 1955</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>11 MARCH 1882</u>	
9. AGE (In years - last birthday) <u>73</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERGYMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>ENGLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>WM CASH</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH WHYSELL</u>		14. NAME OF HUSBAND OR WIFE <u>MARGARETTA CASH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>HOSPITAL RECORDS</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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>4200</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arterionephrosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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 <u>8-6-</u> , 19 <u>55</u> , to <u>8-18-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-18</u> , 19 <u>55</u> , and that death occurred at <u>10:48</u> a.m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Harold H. Lurie, M.D.</u> (Degree or title)				23b. ADDRESS <u>609 Cherry Springfield, Mo.</u>		23c. DATE SIGNED <u>8-19-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Aug 20-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield Mo.</u>	
DATE REC'D BY LOCAL REG. <u>8-23-55</u>		REGISTRAR'S SIGNATURE. <u>Edith Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J.W. Klingner & Co.</u>		ADDRESS <u>SPGFD. MO.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

OCT 3 1955

1955
SEP 7

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 *Max H. ...*

Licensed Embalmer No.

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P. O. Address *Spring*

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.