

FILED SEP 6 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25813

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 758

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>8 days</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>MOZARK OSTEOPATHIC HOSPITAL</u>		e. STREET ADDRESS (If rural, give location) <u>2039 Wayland Drive</u> <u>23960</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Miranda</u>	b. (Middle)	c. (Last) <u>Earp</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>8</u> <u>28</u> <u>1955</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>April 25, 1859</u>	9. AGE (In years last birthday) <u>96</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 60 MIN. Hours	IF UNDER 15 MIN. Mins.
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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	11. BIRTHPLACE (City and State or Foreign Country) <u>Kentucky</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Jed Davis</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Hickman</u>	14. NAME OF HUSBAND OR WIFE <u>Walter M. Earp</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Lou O'Shaughnessy, Springfield,</u>
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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, 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>Medullary failure.</u>		
	ANTECEDENT CAUSES DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>334X</u> 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 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 8/28/55, 1955, to 8/28/55, 1955, that I last saw the deceased alive on 8/28/55, 1955, and that death occurred at 11:10AM, from the causes and on the date stated above.

23a. SIGNATURE <u>Deland E. Wetzell</u>	(Degree or title) <u>MD</u>	23b. ADDRESS <u>700 E. Sunshine</u>	23c. DATE SIGNED <u>8/28/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>	24b. DATE <u>8-30-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lamar</u>	24d. LOCATION (City, town, or county) (State) <u>Lamar, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>8-29-55</u>	REGISTRAR'S SIGNATURE <u>Edith Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>H. L. Polmeyer</u>	ADDRESS <u>Springfield, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... Gene C. Hunter

Licensed Embalmer No. 47

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F  
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.