

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29507

State File No.

 BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 871

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 SPRINGFIELD	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 HANDLEY HOSPITAL		e. STREET ADDRESS (If rural, give location) 1417 N WARREN	
3. NAME OF DECEASED (Type or Print) a. (First) ETHEL b. (Middle) ELIZABETH c. (Last) SKIDMORE		4. DATE OF DEATH (Month) (Day) (Year) OCT. 3, 1955	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH JULY 8, 1884
9. AGE (In years last birthday) 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. BIRTHPLACE (City and State or Foreign Country) POLK COUNTY MISSOURI
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES DYAL	
13b. MOTHER'S MAIDEN NAME SWAPLEY		14. NAME OF HUSBAND OR WIFE WIDOWED	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give major dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT'S SIGNATURE OR NAME HOSPITAL RECORDS		ADDRESS	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia + Cerebral Hemorrhage ANTECEDENT CAUSES Hypertensive Cardiac Vascular Disease Morbidity 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. 443X	
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) m.		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>Sept. 18</u> , 19 <u>55</u> , to <u>Oct. 3</u> , 1955, that I last saw the deceased alive on <u>Oct. 3</u> , 1955, and that death occurred at <u>1:30 p.m.</u> , 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 10-1-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 10-6-55	
24c. NAME OF CEMETERY OR CREMATORY BRIGHTON CEMETERY		24d. LOCATION (City, town, or county) (State) BRIGHTON, MO.	
DATE REC'D BY LOCAL REG. 10-6-55		REGISTRAR'S SIGNATURE Josith Williams	
FUNERAL DIRECTOR'S SIGNATURE J.W. Rhingre		ADDRESS SPRINGFIELD, MISSOURI	

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. *460*

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.