

FILED JAN 30 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DR. CALLOWAY 1014
State File No.

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 76

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 town) SPRINGFIELD		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN SPRINGFIELD
d. FULL NAME OF HOSPITAL OR INSTITUTION BAPTIST HOSPITAL		e. STREET ADDRESS (If rural, give location) 743 S. MAIN	
3. NAME OF DECEASED (Type or Print) a. (First) BERTHA		b. (Middle)	c. (Last) GAFERT
4. DATE OF DEATH (Month) (Day) (Year) JAN 20 1956	5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, WIDOWED (Specify)
8. DATE OF BIRTH AUG. 12, 1872	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) GERMANY	
13a. FATHER'S NAME (UNKNOWN) MASSELL		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE FRED GAFERT
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No (if unknown)) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. ?	17. INFORMANT'S SIGNATURE OR NAME ADDRESS MISS ELLA GAFERT SPRINGFIELD, 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia, Lobar INTERVAL BETWEEN ONSET AND DEATH 1 week ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Emphysema, Diffuse Obstructive DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 490x	
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 Jan 20, 1952 , to Jan 20, 1955 , that I last saw the deceased alive on Jan 20, 1952 , and that death occurred at 8:25 P.M. from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Dr. Calloway MD		23b. ADDRESS 1211 S. Glenmore Springfield, Mo.	23c. DATE SIGNED Jan 23, 56
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1/23/56	24c. NAME OF CEMETERY OR CREMATORY MAPLE PARK CEMETERY	24d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO.
DATE REC'D BY LOCAL REG. 1-24-56	REGISTRAR'S SIGNATURE Edith Williamson	25. PUBLIC HEALTH DIRECTOR'S SIGNATURE Edith Williamson	ADDRESS SPRINGFIELD, MO.

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.....
Lucien T. Swadley
Licensed Embalmer No.....

P. O. Address

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.