

FILED MAR 26 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8767

DR. CALLOWAY

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>265</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) <u>3 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>ST. JOHN'S HOSP.</u>				e. STREET ADDRESS (If rural, give location) <u>447 S. ROBERSON</u> <span style="float: right;">0340</span>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>GERALDENE</u>			b. (Middle) <u>C.</u>		c. (Last) <u>LUNSFORD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 20 1956</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>DIVORCED</u>		8. DATE OF BIRTH <u>JAN. 31 1925</u>	9. AGE (In years last birthday) <u>31</u>	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) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MFA PACKING CO.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>GROVE SPRINGS, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Dena Lunsford</u>			13b. MOTHER'S MAIDEN NAME <u>RUTH REED</u>		14. NAME OF HUSBAND OR WIFE _____				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>1946-1947</u>		17. INFORMANT'S SIGNATURE OR NAME <u>MRS. RUTH OLLIE</u> ADDRESS <u>SPRINGFIELD, MO</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* <u>(a) Diffuse Brain Injury</u>  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. <span style="float: right;">8234</span>				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) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>		21c. (CITY, TOWN, OR TOWNSHIP) <u>Clay Twp</u> (COUNTY) <u>Greene</u> (STATE) <u>Missouri</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>March 17 1956 1:45 a.m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Auto in which he was riding left road at high speed, turning over and crushing my ribs and</u>					
22. I hereby certify that I attended the deceased from <u>March 17, 1956</u> , to <u>March 20, 1956</u> , that I last saw the deceased alive on <u>March 19, 1956</u> , and that death occurred at <u>1:10 a.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Dr. Callaway, Jr</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>Springfield, Mo</u>		23c. DATE SIGNED <u>3/21/56</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>3/22/56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>WHITE CHAPEL</u>		24d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD, MISSOURI</u>			
DATE REC'D BY LOCAL REG. <u>3-22-56</u>		REGISTRAR'S SIGNATURE <u>Edith Williamson</u>		25. GENERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>SPRINGFIELD, MO.</u>			

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

APR 17 1935

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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 embalmed by me, or by ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.. *Luciano J. Gualdo* .....

Licensed Embalmer No. *5875* .....

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.