

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **8823**

No. 300  
10-48

**DR. HALL**  
**FILED APR 2 - 1956**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 281

<b>1. PLACE OF DEATH</b> a. COUNTY <u>GREENE</u>		<b>2. USUAL RESIDENCE</b> (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>1 DAY</u>	c. CITY OR TOWN <u>SPRINGFIELD</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>HANDLEY MEMORIAL HOSP.</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
		e. STREET ADDRESS (If rural, give location) <u>ROUTE # 9 BOX # 651</u>	

<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <u>COLUMBIS</u> b. (Middle) _____ c. (Last) <u>TEAGUE</u>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>MARCH 24 1956</u>		
--	--	--	---	--	--

<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>WIDOWED</u>	<b>8. DATE OF BIRTH</b> <u>FEB. 14 1880</u>	<b>9. AGE</b> (In years last birthday) <u>76</u>	<b>10. IF UNDER 1 YEAR</b> Months _____ Days _____	<b>11. IF UNDER 24 HRS.</b> Hours _____ Min. _____
---------------------------	--------------------------------------	--	---	--	--	--

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>LABORER</u>	<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <u>FORSYTH, MISSOURI</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>
---	---	--	--

<b>13a. FATHER'S NAME</b> <u>ABBOTT TEAGUE</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>SARAH ESCLIK</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>X</u>
--	--	---

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>	<b>16. SOCIAL SECURITY NO.</b> <u>?</u>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <u>LEONA YOUNG</u>	<b>ADDRESS</b> <u>SPRINGFIELD, MO.</u>
--	---	---	--

<b>18. CAUSE OF DEATH</b> 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.	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Cerebral Hemorrhage</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>over 24 hrs</u>
	<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
	<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.		

<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-------------------------------	---	---

<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> _____
---	---	--

<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>
--	---	-----------------------------------

**22. I hereby certify that I attended the deceased from 3/23, 1956, to 3/24, 1956, that I last saw the deceased alive on 3/24, 1956, and that death occurred at NOON m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> (Degree or title) <u>David H. Hall, MD</u>	<b>23b. ADDRESS</b> <u>1951 S. Main, Springfield, Mo</u>	<b>23c. DATE SIGNED</b> <u>3/30/56</u>
--	--	--

<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>24b. DATE</b> <u>3/28/56</u>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>Galloway Cemetery</u>	<b>24d. LOCATION</b> (City, town, or county) (State) <u>Galloway Missouri</u>
--	---------------------------------	--	---

<b>DATE REC'D BY LOCAL REG.</b> <u>3-30-56</u>	<b>REGISTRAR'S SIGNATURE</b> <u>Edith Williamson</u>	<b>FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u>	<b>ADDRESS</b> <u>SPRINGFIELD, MO.</u>
--	--	--	--

(Licensed Embalmer's Statement on Reverse Side)

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 *Levin T. Swadley*.....

Licensed Embalmer No. *4805*.....

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.