

Dr. John Williams Jr. THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

23300

FILED AUG 13 1956

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 718

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, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mercy Hospital		Length of stay in lb 31 Yrs.	d. STREET ADDRESS (If outside, give location) 957 S. Fremont Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First DELIA Middle JOHNSON Last JOHNSON			4. DATE OF DEATH Month Aug. Day 5 Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9 1868
9. AGE (In years last birthday) 88		IF UNDER 1 YEAR Months 8 Days 29 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 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 country) Alton, Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Benjamin Gum	
14. MOTHER'S MAIDEN NAME Elizabeth (Unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT Address W.C. Johnson Springfield, Mo.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Generalized Arterio-sclerosis DUE TO (c) 4260			INTERVAL BETWEEN ONSET AND DEATH year year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arterio-sclerosis - has been a bed patient for years.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 1:30 Month Aug Day 2 Year 1955 a. m. a. m. p. m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Feb 2 - 1955 , to Aug 5 1955 and last saw her alive on 7-24-56 Death occurred at 1:30 a. m. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John Williams Jr. M.D. (Degree or title)		22b. ADDRESS Springfield Mo.	22c. DATE SIGNED 8-6-56
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Aug 7, 1956	23c. NAME OF CEMETERY OR CREMATORY Smith Cemetery	23d. LOCATION (City, town, or county) (State) Alton, Missouri
24. FUNERAL DIRECTOR ADDRESS H.H. Lohmeyer Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 8-9-56	26. REGISTRAR'S SIGNATURE Edna Williams

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
J. J. McCarran

Licensed Embalmer No. *2*

P. O. Address *Spring*

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