

Dr. Klingner
 FILED OCT 15 1956

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **30429**
 Registrar's No. **910**

Registration District No. **128** Primary Registration District No. **2000**

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		c. CITY OR TOWN Springfield 0396	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hosp.		d. STREET ADDRESS (If outside, give location) Route # 11	
Length of stay in 1b 30 Yrs.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First VICTOR Middle Last NELSON			4. DATE OF DEATH Oct. 6 1956		
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5. SEX Male	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 Oct. 11 1879	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Blacksmith	10b. KIND OF BUSINESS OR INDUSTRY Frisco R.R.	11. BIRTHPLACE (City and state or country) FAIRFIELD, IOWA	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME UNKNOWN	14. MOTHER'S MAIDEN NAME UNKNOWN
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. ?	17. INFORMANT Mrs. Lucy Nelson Address Rt #11 Spfld, Mo
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 wks.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		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.)
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20c. TIME OF INJURY Hour Month Day Year a. m. p. m. 	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION	20f. COUNTY	20g. STATE
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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	20g. COUNTY	20h. STATE
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21. I attended the deceased from **9-14-56** to **10-6-56** and last saw her/him alive on **10-6-56**
 Death occurred at **5 p.m.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) D. M. Klingner M.D.	22b. ADDRESS 1630 N. Jefferson, Spfg, Mo	22c. DATE SIGNED 10-8-56
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/9/56	23c. NAME OF CEMETERY OR CREMATORY Maple Park	23d. LOCATION (City, town, or county) (State) Springfield, Mo.
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24. FUNERAL DIRECTOR H.H. Lohmeyer ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 10-9-56	26. REGISTRAR'S SIGNATURE Edith Williamson
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300
1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

MEDICAL CERTIFICATION

OCT 15 1956

NOV 2 1956

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 *Lucretia J. Shadley*

Licensed Embalmer No. *48*

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.