

Dr. Wakeman

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33669

FILED OCT 22 1956

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 941

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		c. CITY OR TOWN <b>Springfield</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>619 S. New</b>		d. STREET ADDRESS (If outside, give location) <b>619 S. New</b>	
3. NAME OF DECEASED (Type or print) <b>MARY</b>		4. DATE OF DEATH <b>Oct. 14 1956</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 30 1861</b>	
9. AGE (In years last birthday) <b>95</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home</b>	
11. BIRTHPLACE (City and state or country) <b>Carlinville, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William (Unknown)</b>		14. MOTHER'S MAIDEN NAME <b>Mary Brandes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>William Lachmund</b>		Address <b>Springfield, Mo.</b>	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <b>Chronic Myocarditis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>months</b>
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 (n) <b>Carcinoma Colon Ascending</b>			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 Month, Day, Year 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 <b>Aug 56</b> to <b>Oct '56</b> and last saw her alive on <b>10-14-56</b> Death occurred at <b>2:30 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>J. Newton Wakeman M.D.</b>		22b. ADDRESS <b>Springfield Mo</b>	
22c. DATE SIGNED <b>10-18-56</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/17/56</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>D.O.O.F. Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Marionville, Mo.</b>	
24. FUNERAL DIRECTOR <b>H.H. Lohmeyer</b>		25. DATE RECD. BY LOCAL REG. <b>10-16-56</b>	
ADDRESS <b>Springfield, Mo.</b>		26. REGISTRAR'S SIGNATURE <b>Edith Williams</b>	

(Licensed Embalmer's Statement on Reverse Side)

Health,  
Welfare  
Public  
Service300  
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *Juan L. Lopez* .....

Licensed Embalmer No. *487* .....

P. O. Address *Franklin* .....

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.