

Health,
Welfare
Public
Service

300
1-56

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33711

FILED OCT 22 1956

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 929

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 Republic 390	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE OZARK OSTHOPEATHIC HOSPITAL		d. STREET ADDRESS Rte #1 N.W.	
Length of stay in lb 1 day		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Culbertson Viles			4. DATE OF DEATH 10-11-56
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 4-6-1878
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Farming		9b. KIND OF BUSINESS OR INDUSTRY Farmer	9c. AGE (In years last birthday) 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	10c. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) Ozark, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Viles		14. MOTHER'S MAIDEN NAME Laura Litteral	
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. Yes	
17. INFORMANT Rebecca E. Viles		Address Rte #1 Republic, 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) Circulatory Failure			INTERVAL BETWEEN ONSET AND DEATH 6 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) acute decompensated cor Pulmonale			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 10-11-56 to 10-11-56 and last saw her/him alive on 10-11-56 Death occurred at 11:15 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Anders Martensick, D.O.		22b. ADDRESS Springfield, Mo	
22c. DATE SIGNED 10-12-56			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-12-56	23c. NAME OF CEMETERY OR CREMATORY Garoutte Cemetery	23d. LOCATION (City, town, or county) (State) Republic Mo
24. FUNERAL DIRECTOR Centrell-Fossett		25. DATE RECD. BY LOCAL REG. 10-18-56	
ADDRESS Republic Mo.		26. REGISTRAR'S SIGNATURE Edith Williamson	

(I, Licensed Embalmer's Statement on Reverse Side)

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 *William B. Coates*

Licensed Embalmer No. *48*

P. O. Address *Spokane*

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