

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

FILED DEC 3 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32633  
STATE FILE NUMBER  
Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1093

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> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Springfield</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>615 S. Park</b>		d. STREET ADDRESS <b>615 S. Park</b> (If outside, give location)	
Length of stay in lb <b>47 Yrs.</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>NOAH</b> Middle <b>E.</b> Last <b>CALTON</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>28</b> Year <b>1956</b>			
5. SEX <b>Male</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>3 Sept. 1877</b>	9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Yard Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber Yard</b>		11. BIRTHPLACE (City and state or country) <b>Missouri</b>		
13. FATHER'S NAME <b>Ephrem Calton</b>			12. CITIZEN OF WHAT COUNTRY <b>USA</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.		17. INFORMANT <b>Edna Calton</b> Address <b>Springfield, Mo.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction (by history)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</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 (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.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month _____ Day _____ Year _____		
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 \_\_\_\_\_ to **Nov 28, 1956** and last saw her alive on \_\_\_\_\_  
Death occurred at **8:45 P.M.** \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>George L. Johnson, M.D.</b> (Degree or title)	22b. ADDRESS <b>16368 Glenstone, Springfield, Mo.</b>	22c. DATE SIGNED <b>11/29/56</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 1, 1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>J. Klingner &amp; Co. Spgfd. Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-29-56</b>	26. REGISTRAR'S SIGNATURE <b>Edith Williams</b>

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 *Ogle Stone Jr.*

Licensed Embalmer No. *4170*

P. O. Address *Greenville*

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.

15-11-1918