

37669

HEALTH DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 19 1956

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1023

Health,
Welfare
Public
Service300
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 causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. 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 Burge			Length of stay in 1b 28 yrs.		d. STREET ADDRESS (If outside, give location) 722 E. Normal		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First WALTER Middle PEARCE Last HULL				4. DATE OF DEATH Month Nov. Day 8, Year 1956									
5. SEX Male <input type="checkbox"/> <input checked="" type="checkbox"/>		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 Nov. 22, 1870		9. AGE (In years past birthday) 85		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant				10b. KIND OF BUSINESS OR INDUSTRY Accountant		11. BIRTHPLACE (City and state or country) Eyota, Minnesota			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Joseph Hull						14. MOTHER'S MAIDEN NAME Eliza Westfall							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes \$pan.American				16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Lenne Hull Address Springfield Mo 722 E. Normal							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Esophagus										INTERVAL BETWEEN ONSET AND DEATH 1 year			
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 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.) 150x										
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 Aug. 19, 56 to Nov. 8, 1956 and last saw him alive on Nov. 7-56 Death occurred at 5:55 A. m on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) Gene W. Fairberg M.D.				22b. ADDRESS 808 Mad ants Springfield Mo				22c. DATE SIGNED 11/8/56					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 13 1956		23c. NAME OF CEMETERY OR CREMATORY NATIONAL				23d. LOCATION (City, town, or county) (State) Springfield, Mo.					
24. FUNERAL DIRECTOR ADDRESS Ralph Thieme Springfield, Mo					25. DATE RECD. BY LOCAL REG. 11-13-56		26. REGISTRAR'S SIGNATURE Emt. W. Williams						

(Licensed Embalmer's Statement on Reverse Side)

MAR 27 1959

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 *Lee Mason*.....

Licensed Embalmer No. 4568

P. O. Address Springfield,

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.