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

37687
STATE FILE NUMBER

FILED NOV 19 1956

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1029

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Burge — Length of stay in 1b 8 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Greene
c. CITY OR TOWN Springfield 3960 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1820 W. Olive — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First NELLIE Middle JEANE Last MATHIAS

4. DATE OF DEATH Month Nov. Day 10, Year 1956

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH June 19, 1886
9. AGE (In years last birthday) 70 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (City and state or country) Nixa, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James A. Harp
14. MOTHER'S MAIDEN NAME Isabelle Reynolds
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. None
17. INFORMANT Mr. William Mathias Address 1820 W. Olive Springfield, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CANCER OF GALL bLADDER — INTERVAL BETWEEN ONSET AND DEATH NOT KNOWN
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) Cardio-Renal-Vascular Disease 155X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 10-18-56, to Nov. 10. 1956 and last saw her alive on 11-9-56
Death occurred at 4:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [signature] (Degree or title) MD
22b. ADDRESS Springfield Medical Bldg. Springfield Mo
22c. DATE SIGNED 11-15-56

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Nov.12,1956
23c. NAME OF CEMETERY OR CREMATORY Greenlawn
23d. LOCATION (City, town, or county) Springfield, (State) Mo.

24. FUNERAL DIRECTOR Ralph Thieme ADDRESS Springfield, Mo.
25. DATE RECD. BY LOCAL REG. 11-16-56
26. REGISTRAR'S SIGNATURE [signature]

(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 em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 4568

P. O. Address Springfield

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