

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

Dr. Wakeman

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41140

STATE FILE NUMBER

FILED JAN 7 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1184

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>1837 N. Golden</b>			Length of stay in 1b <b>70 Yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>1837 N. Golden</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b></b> Last <b>HART</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>29</b> Year <b>1956</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 26 1884</b>		9. AGE (In years last birthday) <b>72</b>	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home</b>			10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (City and state or country) <b>Marion County, Ark. ✓</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Shelt Earls</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Coffey</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 Address <b>Nancy Stiffler 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>Hypertensive Arteriosclerotic Heart Disease with Ascites</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</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 _____ Month, Day, Year _____ a. m. _____ p. m. _____								
20d. INJURY OCCURRED WHILE AT <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>April 1956</b> to <b>Dec 29 '56</b> and last saw her alive on <b>Dec 28 '56</b> Death occurred at <b>12:30 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.								
22. SIGNATURE (Degree or title) <b>J. Newton Wakeman M.D.</b>				22b. ADDRESS <b>Springfield Mo</b>		22c. DATE SIGNED <b>12-29-56</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/31/56</b>	23c. NAME OF CEMETERY OR CREMATOR <b>Eastlawn</b>		23d. LOCATION (City, town, or county) (State) <b>Springfield, Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>H.H. Lohmeyer Springfield, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>12-31-56</b>		26. REGISTRAR'S SIGNATURE <b>Edith Williams</b>			

(Licensed Embolmer's Statement on Reverse Side)

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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 *H. J. McCann*.....

Licensed Embalmer No. *27*.....

P. O. Address *Spring*.....

**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.