

Dr. J. Williams

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41191

STATE FILE NUMBER

FILED DEC 17 1956

Registration District No. 128 Primary Registration District No. 2072 Registrar's No. 1130

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>Newton</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>Seneca</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>Mercy Hosp.</b>		Length of stay in lb <b>2 Yrs.</b>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>DANIEL</b> First <b>E.</b> Middle <b>STUCKEY</b> Last			4. DATE OF DEATH <b>Dec. 12 1956</b> Month <b>Dec.</b> Day <b>12</b> Year <b>1956</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 7 1878</b>	9. AGE (In years last birthday) <b>78</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>30</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Supt.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Exchange</b>	11. BIRTHPLACE (City and state or country) <b>(Unknown)</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Daniel E. Stuckey</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Cunningham</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>495-07-1456</b>	17. INFORMANT <b>Joe Kane</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>Coronary thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>arterio-sclerosis-generalized</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Advanced Hypertrophic arthritis</b>					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 <b>8:30</b> Month <b>12</b> Day <b>12</b> Year <b>1956</b> a. m. <b>p. m.</b>					
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 <b>6-1956</b> to <b>12-12-56</b> and last saw her alive on <b>8:30 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>John Wallace</b> (Degree or title) <b>Ph.D.</b>		22b. ADDRESS <b>Springfield</b>		22c. DATE SIGNED <b>12-13-56</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-13-56</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <b>Seneca, Missouri</b>	
24. FUNERAL DIRECTOR <b>H.H. Lohmeyer</b> ADDRESS <b>Springfield, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12-14-56</b>		26. REGISTRAR'S SIGNATURE <b>Edith Williams</b>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300-56

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

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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 L McCann*

Licensed Embalmer No. *27*

P. O. Address..... *Springfield*

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