

health, Welfare public service
 300 -56
 Doctor, coroner, etc. must use only standard nomenclature in their reports. No symptoms which are unusual. 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

FILED JAN 21 1957

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

952

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 43

1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE					
b. CITY (If outside corporate limits, give TOWNSHIP only) 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 HOSPITAL OR INSTITUTION 424 Mt. Vernon			Length of stay in lb 6 mos.	d. STREET ADDRESS (If outside, give location) 424 Mt. Vernon			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MABEL				First	Middle	Last	4. DATE OF DEATH Jan. 11, 1957		
5. SEX Female	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 Dec. 6, 1908		9. AGE (In years last birthday) 48	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (City and state or country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas Bryant				14. MOTHER'S MAIDEN NAME Mildred Sanderson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mildred Sanderson, Gainesville, Mo.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction							INTERVAL BETWEEN ONSET AND DEATH 24-36 hrs		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Coronary artery occlusion (According to report of Pathologist)							
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION WHEN IN PART I (a) Acute Alcoholism							19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 date of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			UNATTENDED BY PHYSICIAN 4201						
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 _____ and last saw her alive on _____ Death occurred at about 1:30 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>Cartha Williams</i> (Degree or title) Local Registrar of Vital Statistics				22b. ADDRESS Greene County Court House Springfield Mo			22c. DATE SIGNED 1-15-57		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/14/57	23c. NAME OF CEMETERY OR CREMATORY Hazelwood Cemetery		23d. LOCATION (City, town, or county) (State) Springfield, Missouri				
24. FUNERAL DIRECTOR ADDRESS AYRE-GOODWIN, Inc. Springfield, Mo			25. DATE RECD. BY LOCAL REG. 1-15-57		26. REGISTRAR'S SIGNATURE <i>Cartha Williams</i>				

(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 embalmed
by me, or by Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Lucas T. Swabley*.....

Licensed Embalmer No. *480*

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.