

Health, Welfare  
Public Service

300  
1-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. Silsby  
FILED FEB 11 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

955  
STATE FILE NUMBER  
Registration District No. 129 Primary Registration District No. 2000 Registrar's No. 139

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>815 N. Main</b>		Length of stay in 1b <b>42 Yrs.</b>	d. STREET ADDRESS <b>815 N. Main</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LAMBERT</b> Middle <b>B.</b> Last <b>HIGHT</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>6</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 14 1878</b>	9. AGE (In years last birthday) <b>78</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mail Carrier</b>	11. BIRTHPLACE (City and state or country) <b>Fayetteville, Ark.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>James R. Hight</b>			14. MOTHER'S MAIDEN NAME <b>Helen Blevins</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>491-03-6993</b>	17. INFORMANT Address <b>Mrs. Ruth E. Hight Spfld, 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>Congenital Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>mitral insufficiency</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (1a)					INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>unknown</b> <b>11</b>
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.) <b>H10X</b>		
20c. TIME OF INJURY. Hour <input type="checkbox"/> Month, Day, Year <input type="checkbox"/>					
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 <b>Springfield Greene Mo.</b>		STATE <b>Mo.</b>
21. I attended the deceased from <b>Mar 13 1956</b> to <b>Feb 6, 1957</b> and last saw him alive on <b>Feb 5 57</b> Death occurred at <b>12 noon</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>[Signature]</i>			22b. ADDRESS <b>609 Cherry St</b>		22c. DATE SIGNED <b>Feb 6 57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2/9/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Maple Park</b>		23d. LOCATION (City, town, or county) (State) <b>Springfield, Mo.</b>	
24. FUNERAL DIRECTOR <b>H.H. Lohmeyer</b>		ADDRESS <b>Springfield, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>2-7-57</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</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 *R. L. Mc Carr*.....

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

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

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.