

FILED FEB 4 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

958

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 82-A

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> <sup>0396</sup>		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>717 W. State</b>		Length of stay in lb <b>3 yrs.</b>	d. STREET ADDRESS <b>717 W. State</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>Lawrence</b> Middle <b>W.</b> Last <b>Howe</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>21</b> Year <b>1957</b>		
5. SEX <b>Male</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. 1, 1957</b>	9. AGE (In years last birthday) <b>78</b> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Traveling</b>	11. BIRTHPLACE (City and state or country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>487-05-4929</b>	17. INFORMANT Address <b>Mrs. Annabel Howe-Park Forest, Ill.</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>Cardio-Vascular Disease</b>					INTERVAL BETWEEN ONSET AND DEATH
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"/> <b>3</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.)		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____					
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 <u>Sept 14, 1956</u> to <u>Death</u> and last saw <sup>her</sup> him alive on <u>Jan 14, 1957</u> Death occurred at <u>11:00 p.</u> m on the date stated above; and to the best of my knowledge from the causes stated.					
22a. SIGNATURE <b>Leman D. Brown M.D.</b> (Degree or title)		22b. ADDRESS <b>311 1/2 College</b>		22c. DATE SIGNED <b>1/28/57</b>	
23a. BURIAL, CREMATION, TREATMENT (Specify) <b>Burial</b>		23b. DATE <b>1-24-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Springfield, Missouri.</b>
24. FUNERAL DIRECTOR <b>Ar. Roney</b> ADDRESS <b>Springfield, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>1-28-57</b>		26. REGISTRAR'S SIGNATURE <b>Loth. Williams</b>	

(Licensed Embalmer's Statement on Reverse Side)

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in reporting diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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  .....

Licensed Embalmer No. 3312

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.