

FILED FEB 25 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4315

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 158-B

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY		Greene		a. STATE		Missouri	
b. CITY (If outside corporate limits, give TOWNSHIP only)		Springfield		b. COUNTY		Greene	
OR TOWN		Springfield		c. CITY OR TOWN		Springfield 0396	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Mercy Hospital		d. STREET ADDRESS		711 Cherry	
Length of stay in lb		10 Yrs.		(If outside, give location)		Reside on Farm	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First		Middle		Month		Day	
NANNIE		CLAY		Feb. 11,		1957	
Last		DILLON		Year			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		White /		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 Aug. 1867	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
89		Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (City and state or country)			
Housewife Home				100. KIND OF BUSINESS OR INDUSTRY			
				Missouri 0			
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?			
Joseph Holladay				USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year & dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
No N				No		Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Fracture left Femur</u>							
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)							
INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>							
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 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	
						Springfield, Mo.	
21. I attended the deceased from <u>Jan 3, 1957</u> to <u>Feb 11, 1957</u> and last saw her alive on <u>Feb 9, 1957</u> . Death occurred at <u>9:48 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title)				22b. ADDRESS		22c. DATE SIGNED	
<u>James T. Ford M.D.</u>				Springfield, Mo.		2-15-57	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		2-14-57		Greenlawn		Springfield, Mo.	
24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	
<u>J. W. Plummer Co. Spgfd. Mo.</u>				2-18-57		<u>Edith Williamson</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Caroner cannot certify to a death due to natural causes. diseases in Part I must be causally related.

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.

P. O. Address.....

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.