

FILED FEB 18 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4333

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 156

1. PLACE OF DEATH a. COUNTY <b>Greene</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Cherokee</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Y <input checked="" type="checkbox"/> N <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Baxter Springs</b>		Inside Limits Y <input checked="" type="checkbox"/> N <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>			Length of stay in lb <b>3 weeks</b>			d. STREET ADDRESS (If outside, give location) <b>Baxter Springs</b>	
3. NAME OF DECEASED (Type or print) <b>LINDA</b> First <b>CHRISTINE</b> Middle <b>JARMAN</b> Last				4. DATE OF DEATH Month <b>Feb</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 21, 1952</b>		9. AGE (In years last birthday) <b>4</b>	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) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (City and state or country) <b>Baxter Springs, Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Willis B. Jarman</b>				14. MOTHER'S MAIDEN NAME <b>Betty</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>None</b>		17. INFORMANT Address <b>Mrs. Betty Jarman, Baxter Springs, Kans</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>Pneumonia</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>7573</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Horse shoe kidneys, hydroureter, cortical hypoplasia, cortical hemorrhages</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.) <b>2</b>				
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 <b>1/21/57</b> to <b>2/11/57</b> and last saw her/him alive on <b>2/10/57</b> . Death occurred at <b>7:20 a</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>David D. Thomson M.D.</b>				22b. ADDRESS <b>1600 N. Jefferson</b>		22c. DATE SIGNED <b>2/14/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>2/12/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baxter Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baxter Springs, Kansas</b>		
24. FUNERAL DIRECTOR ADDRESS <b>H. H. Lohmeyer, Springfield, Missouri</b>				25. DATE RECD. BY LOCAL REG. <b>2-15-57</b>		26. REGISTRAR'S SIGNATURE <b>Edith Williams</b>	

(Licensed Embalmer's Statement on Reverse Side)

300  
-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Paul Shiner* .....  
Licensed Embalmer No. ....

P. O. Address *Spfld., Ill.* .....

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.