

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

7306

FILED FEB 26 1957

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 33

1. PLACE OF DEATH a. COUNTY VERNON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WASHINGTON TOWNSHIP Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN SPRINGFIELD ⁰³⁹⁶ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR STATE HOSPITAL #3 INSTITUTION NEVADA, Mo. Length of stay in 1b 12 yrs 9 mo 29 days		d. STREET ADDRESS 1122 E. CENTRAL Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) AMANDA First Middle Last MEDLEY			4. DATE OF DEATH Month Day Year Feb 7 1957		
5. SEX F	6. COLOR OR RACE WH	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/3/1890	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months Days Hours Min. 10 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	11. BIRTHPLACE (City and state or country) MARIES CO, MO.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRITZ SUDHEIMER			14. MOTHER'S MAIDEN NAME SUSAN VANDERPOOL		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give year or dates of service) UNK		16. SOCIAL SECURITY NO. UNK (No.)	17. INFORMANT Address PAPERS STATE HOSPITAL #3 NEVADA, 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) BRONCHIOGENIC CARCINOMA OF LUNGS		INTERVAL BETWEEN ONSET AND DEATH YEARS
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"/>

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.) NONE	
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.) NONE	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from DEC 31, 1956 to FEB. 7, 1957 and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) George Escher, M. D.	22b. ADDRESS State Hospital #3, Nevada, Mo.	22c. DATE SIGNED 2/7/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Feb. 7, 1957	23c. NAME OF CEMETERY OR CREMATORY White Chapel Cem.	23d. LOCATION (City, town, or county) (State) Springfield, Mo.
24. FUNERAL DIRECTOR'S ADDRESS Frank L. Phelan Nevada - 100	25. DATE RECD. BY LOCAL REG. 2-20-1957	26. REGISTRAR'S SIGNATURE Anna G. Perry	

(Licensed Embalmer's Statement on Reverse Side)

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56
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Health, Welfare, Public Service

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56

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

MAR 5 1958

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 *Clayton M. Carl*.....

Licensed Embalmer No. 485

P. O. Address *Peoria,*.....

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.