

FILED APR 1 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8280

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 270

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Springfield ⁰³⁹⁸		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital			Length of stay in 1b 21 months		d. STREET ADDRESS (If outside, give location) Route 8		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle RUFF Last GORSUCH				4. DATE OF DEATH Month March Day 21 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 3, 1871		9. AGE (In years last birthday) 85	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) Retired Judge		10b. KIND OF BUSINESS OR INDUSTRY Greene Co. Court		11. BIRTHPLACE (City and state or country) Cave Springs, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Reese Gorsuch				14. MOTHER'S MAIDEN NAME Eliza Jane Brower			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs B. B. Johnson, Springfield, Missouri		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor. Aoe Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Cardiorenal Disease DUE TO (c) Arteriosclerosis						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)						19. WAS AUTOPSY PERFORMED? 2 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 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 Mar 11/57 to Mar 21/57 and last saw her alive on Mar 21 Death occurred at 2:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) W. Deibel M.D.				22b. ADDRESS Springfield Mo		22c. DATE SIGNED 3/23/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 23, 1957		23c. NAME OF CEMETERY OR CREMATORY Wesley Cemetery		23d. LOCATION (City, town, or county) (State) Willard, Missouri	
24. FUNERAL DIRECTOR Greene Wade-Windle ADDRESS Willard, Mo.				25. DATE RECD. BY LOCAL REG. 3-26-57		26. REGISTRAR'S SIGNATURE Edith Williamson	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300-56

Director, Coroner, etc. must use only standard nomenclature when reporting symptoms or cause of death. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be casually related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Robert E. McPherson*

Licensed Embalmer No. *491*

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.