

Dr. Lemmon

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8284

STATE FILE NUMBER

FILED APR 15 1957

 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 353

 Health,
Welfare
Public
Service
300
1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hosp.</u>		Length of stay in 1b <u>7 Yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>2750 W. Chestnut</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ORVILLE</u> Middle <u>V.</u> Last <u>GROSE</u>				4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 15 1895</u>		9. AGE (In years last birthday) <u>61</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trucker--Frisco</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trans. Co.</u>		11. BIRTHPLACE (City and state or country) <u>Tyrone, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ples Grose</u>				14. MOTHER'S MAIDEN NAME <u>Mary Curtis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W. # 1</u>		16. SOCIAL SECURITY NO. <u>487-09-2184</u>		17. INFORMANT <u>Mrs. Bessie Grose</u> Address <u>Springfield, Mo.</u>			
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>Coronary thrombosis acute</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</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 (n)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>	
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 _____ a. m. _____ p. m.			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased <u>on 4-8-57</u> and last saw <u>her</u> alive on <u>4-8</u> Death occurred at <u>12:55 a.m.</u> <u>Springfield, Mo.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Dr. Lemmon, M.D.</u> (Degree or title)				22b. ADDRESS <u>Springfield, Mo.</u>		22c. DATE SIGNED <u>4-9-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/11/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cabool Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Cabool, Mo.</u>		
24. FUNERAL DIRECTOR <u>H.H. Lohmeyer</u> ADDRESS <u>Springfield, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>4-11-57</u>		26. REGISTRAR'S SIGNATURE <u>Edith Williams</u>		

(Licensed Embalmer's Statement on Reverse Side)

APR 15 1957

AUG 26 1958

APR 18 1957

Funeral Home

6000-2-701

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 *Gene Lohme* _____

Licensed Embalmer No. 47

P. O. Address *St. Paul*

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.