

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8290

STATE FILE NUMBER

FILED APR 15 1957

21298-57 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 358

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 ⁰³⁹⁶ Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital		Length of stay in lb 3 Days	d. STREET ADDRESS RFD#1 (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GARY Middle KENT Last HEADLEE			4. DATE OF DEATH Month April Day 11 Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 Apr. 1957
9. AGE (In years last birthday) 0	IF UNDER 1 YEAR Months 0 Days 3 Hours Min. 	10. KIND OF BUSINESS OR INDUSTRY Infant	11. BIRTHPLACE (City and state or country) Springfield, Missouri
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY Infant	11. BIRTHPLACE (City and state or country) Springfield, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Gary Ted Headlee		14. MOTHER'S MAIDEN NAME Mary Sue Allen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. N	17. INFORMANT Hospital Records Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 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) 776X			INTERVAL BETWEEN ONSET AND DEATH 2 days
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, Missouri COUNTY Greene STATE Missouri	
21. I attended the deceased from 8 April 57 to 11 Apr 57 and last saw her alive on 10 Apr 57 Death occurred at 10:56 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J. Kenneth E. Knabb, M.D. (Type or Print)		22b. ADDRESS 1630 N. Jefferson Springfield, Missouri	22c. DATE SIGNED 11 Apr 57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-12-57	23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort	23d. LOCATION (City, town, or county) (State) Greene County, Missouri
24. FUNERAL DIRECTOR J. Williams + Co. ADDRESS Spgrfd. Mo.		25. DATE RECD. BY LOCAL REG. 4-12-57	26. REGISTRAR'S SIGNATURE Edith Williams

Name of Deceased _____
 Date of Death _____
 Place of Death _____
 Age at Death _____
 Sex _____
 Race _____
 Cause of Death _____
 Manner of Death _____
 Name of Physician _____
 Name of Hospital _____
 Name of City _____
 Name of State _____

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 *Glenn A. Williams*

Licensed Embalmer No. *46*

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.

FORM 1-19-23