

FILED APR 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **8377**
Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 337

1. PLACE OF DEATH a. COUNTY Greene		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 Springfield Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Springfield Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 03960	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Handley Length of stay in lb 15 Mon'		d. STREET ADDRESS (If outside, give location) 1368 E Division St Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CYNTHIA ANNE WAIR First Middle Last			4. DATE OF DEATH 4 4 57 Month Day Year
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec' 20 1955 1yr 3Mon'
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 3 Mon' IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (City and state or country) Springfield Mo'		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ballard Wair		14. MOTHER'S MAIDEN NAME Stachie Boyd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Stachie Wair		Address 1368 E Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema			INTERVAL BETWEEN ONSET AND DEATH
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.)		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT <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 4/4/57 to 4/4/57 and last saw her alive on 4/4/57 Death occurred at 8:00p on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Leman D. Brown M.D.		22b. ADDRESS 311 1/2 College	22c. DATE SIGNED 4/4/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-6-57	23c. NAME OF CEMETERY OR CREMATORY Haglewood	23d. LOCATION (City, town, or county) (State) Springfield Mo
24. FUNERAL DIRECTOR H.V. Smith ADDRESS 602 N. Jefferson	25. DATE RECD. BY LOCAL REG. 4-8-57	26. REGISTRAR'S SIGNATURE Edith Williamson	

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 *Herbert V Smith*

Licensed Embalmer No. *421*

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.