

FILED MAY 6 - 1957

## STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 12785

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 406

300  
1-56Health, Welfare  
Public  
Service

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Webster</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Marshfield</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>OSARK OSTEOPATHIC HOSPITAL</b> Length of stay in 1b <b>3 wks</b>		d. STREET ADDRESS (If outside, give location) <b>McVay St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ethel</b> Middle <b>Juanita</b> Last <b>Haggard</b>			4. DATE OF DEATH Month <b>4</b> Day <b>27</b> Year <b>57</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-16-1908</b>
9. AGE (In years last birthday) <b>49</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
100. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (City and state or country) <b>Kansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Jim Hendrickson</b>		14. MOTHER'S MAIDEN NAME <b>Hattie Ryan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT <b>Mr. C. E. Hendrickson</b> Address <b>Springfield, Mo</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Medullary Failure</b> (b) <b>Cerebral Embolic Encephalomalacia.</b> DUE TO (b) <b>Mitral Stenosis and Cardiac Mural Thrombus Formation</b> DUE TO (c) <b>Juvenile Rheumatic Fever.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)			INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
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 <b>4:10</b> Month <b>4</b> Day <b>27</b> Year <b>57</b> a. m. <b>p. m.</b>		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 <b>Marshfield</b> COUNTY <b>MO</b> STATE <b>MO</b>	
21. I attended the deceased from <b>April 24, 1957</b> to <b>April 27, 1957</b> and last saw <b>her</b> alive on <b>4-27-57</b> Death occurred at <b>4:10 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Dress or title) <b>Andrew Martinek M.D.</b>		22b. ADDRESS <b>700 East Sunshine, Springfield, Mo.</b>	22c. DATE SIGNED <b>4-27-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/24/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Marshfield</b>	23d. LOCATION (City, town, or county) (State) <b>Marshfield MO</b>
24. FUNERAL DIRECTOR <b>Barber Edwards</b> ADDRESS <b>Marshfield</b>		25. DATE RECD. BY LOCAL REG. <b>4-30-57</b>	26. REGISTRAR'S SIGNATURE <b>Edith Williamson</b>

(Licensed Embalmer's Statement on Reverse Side)

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 *R. W. Barber*.....

Licensed Embalmer No. *38*

P. O. Address *705 7th*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure 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.