Dr. Peterson

FILED APR 22 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12794
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 364

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 Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mercy Hosp. — Length of stay in 1b 49 Yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Greene
c. CITY OR TOWN Springfield — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS 500 S. Main (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) — First: ELSIE Middle: M. Last: HOPKINS
4. DATE OF DEATH Month: April Day: 13 Year: 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 28 1869
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Paynterville Cedar Co. Mo.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: C.W. Paynter
14. MOTHER'S MAIDEN NAME: Margaret Jackson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Mrs. John F. McKinney Address: Springfield Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerosis generalized
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) —
INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 23 Jan 57, to 13 April 57 and last saw her alive on 8 April 57
Death occurred at 5:45 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title) [signature] M.D.
22b. ADDRESS Springfield - Mo
22c. DATE SIGNED 15 April 57
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4-16-56
23c. NAME OF CEMETERY OR CREMATORY: GREEN WOOD
23d. LOCATION (City, town, or county) (State): Bolivar, Mo.
24. FUNERAL DIRECTOR: H.H. Lohmeyer ADDRESS: Springfield, Mo.
25. DATE RECD. BY LOCAL REG.: 4-16-57
26. REGISTRAR'S SIGNATURE: [signature]

(Licensed Embalmer's Statement on Reverse Side)

APR 29 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed H L McCann

Licensed Embalmer No. 272

P. O. Address Springfield

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