

Dr. Schwartz

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12814

STATE FILE NUMBER

FILED MAY 14 1957

Registration District No.

128

Primary Registration District No.

2000

Registrar's No.

430

| | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|--|
| 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 <i>c346</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hosp. | | | Length of stay in lb 2 Yrs. | | d. STREET ADDRESS 2618 Luster Drive (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First MARTHA Middle JANE Last MENK | | | | 4. DATE OF DEATH May 4 1957 Month Day Year | | | | | |
| 5. SEX Female | | 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 May 10 1955 | | 9. AGE (In years last birthday) 1 IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Kansas City, Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME L.W. Menk | | | | 14. MOTHER'S MAIDEN NAME Martha Jane Swan | | | | | |
| 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. No | | 17. INFORMANT L.W. Menk Address Springfield, Mo. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cardiac Arrest Following Eye Surgery DUE TO (c) _____ 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 | | |
| 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.) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 | |
| 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 | | COUNTY | | STATE | |
| 21. I attended the deceased from May 1, 1957 to May 4, 1957 and last saw her/him alive on May 4, 1957 Death occurred at 10:35 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) E.J. Schwartz M.D. | | | | 22b. ADDRESS Springfield Mo. | | | 22c. DATE SIGNED 5-8-57 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5/7/57 | | 23c. NAME OF CEMETERY OR CREMATORY Hazelwood | | 23d. LOCATION (City, town, or county) Springfield, Mo. | | (State) | |
| 24. FUNERAL DIRECTOR H.H. Lohmeyer ADDRESS Springfield, Mo. | | | 25. DATE RECD. BY LOCAL REG. 5-8-57 | | 26. REGISTRAR'S SIGNATURE Edith Williamson | | | | |

(Licensed Embalmer's Statement on Reverse Side)

Health,
Welfare
Public
Service300
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

MEDICAL CERTIFICATION

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 *H. L. McCarroll*.....

Licensed Embalmer No. *272*

P. O. Address *Springfield*

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.