

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 causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STANDARD CERTIFICATE OF DEATH

16723

STATE FILE NUMBER

FILED MAY 27 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 471-A

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Ozark					
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 Hammond		0770 0 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Baptist Hospital			Length of stay in lb 12 days		d. STREET ADDRESS Marion Township		(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Robert <i>First</i> Russell <i>Middle</i> Farmer <i>Last</i>				4. DATE OF DEATH Month May Day 15 Year 1957					
5. SEX Male <input type="checkbox"/>		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1910		9. AGE (In years law birthday) 47 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY On Farm		11. BIRTHPLACE (City and state or country) Gainesville, Missouri		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Dempsy D. Farmer				14. MOTHER'S MAIDEN NAME Minnie Lance					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None (If yes, give year or dates of service)			16. SOCIAL SECURITY NO. 500-13-0496		17. INFORMANT Address Mrs. Belma Farmer Hammond, 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) Aneurysm of Middle Cerebral Artery							INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
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.) 452X						
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 4, '57 to May 15 '57 and last saw <input checked="" type="checkbox"/> alive on May 15, '57 Death occurred at 12:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) James T. Good M.D.				22b. ADDRESS Springfield, Mo			22c. DATE SIGNED 5-18-57		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 19, 1957		23c. NAME OF CEMETERY OR CREMATORY Thornfield		23d. LOCATION (City, town, or county) Ozark County, Missouri			
24. FUNERAL DIRECTOR Chas. W. Beard Funeral Home Springfield, Missouri (Licensed Embalmer's Statement on Reverse Side)				25. DATE RECD. BY LOCAL REG. 5-21-57		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

Signature *L. Leahn Gorna*

Licensed Embalmer No. *317*

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.