

Health,
Welfare
Public
Service

300
1-56

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.

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER
18100
470

FILED MAY 20 1957

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 470

1. PLACE OF DEATH a. COUNTY Greene			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE California b. COUNTY		
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 San Francisco		80408 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Medical Center for Federal Prisoners		Length of stay in lb 86 days	d. STREET ADDRESS Unknown		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Tom Middle Last Hung			4. DATE OF DEATH Month May Day 15th Year 1957		
5. SEX Male	6. COLOR OR RACE Chinese	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1906	9. AGE (In years last birthday) 50	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dishwasher		10b. KIND OF BUSINESS OR INDUSTRY Varied	11. BIRTHPLACE (City and state or country) Canton, China		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Tom Git			14. MOTHER'S MAIDEN NAME Yee Shee		
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. Unknown	17. INFORMANT Address FILE: MCFP Springfield, Missouri		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition					INTERVAL BETWEEN ONSET AND DEATH 2 Months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hepatocarcinoma					1561 5 Months
DUE TO (c) *****					*****
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) *****					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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.) The Medical Staff	20f. CITY, TOWN, OR LOCATION Springfield		COUNTY STATE
21. I attended the deceased from 2-18-57 to 5-15-57 and last saw him him alive on 5-15-57 Date occurred at 2:30 a m on the date stated above; and to the best of my knowledge, from the causes stated.					
22. SIGNATURE Clarence Kootker, M.D., Act. Clin. Dir.			22b. ADDRESS Medical Center for Federal Prisoners, Springfield		22c. DATE SIGNED 5-15-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-17-57	23c. NAME OF CEMETERY OR CREMATORY Hazelwood Cemetery		23d. LOCATION (City, town, or county) (State) Springfield Mo	
24. FUNERAL DIRECTOR Ray-Hoodwin, Inc.		ADDRESS Springfield, Mo	25. DATE RECD. BY LOCAL REG. 5-16-57	26. REGISTRAR'S SIGNATURE Trista Williamson	

(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 *Lester T. Gledhill*
Licensed Embalmer No. 481

P. O. Address *Spring*

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.