

FILED MAY 20 1957

STANDARD CERTIFICATE OF DEATH

10872
STATE FILE NUMBER

Registration District No. 138 Primary Registration District No. 2000 Registrar's No. 448

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Webster	
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 Marshfield Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION OZARK OSTEOPATHIC HOSPITAL Length of stay in lb 8 days		d. STREET ADDRESS (If outside, give location) Rural Route # 4 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lucinda Jane Smith First Middle Last			4. DATE OF DEATH May 10, 1957 Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1873
9. AGE (In years last birthday) 84		IF UNDER 1 YEAR I Months	IF UNDER 24 HRS. I Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Dallas County, Mo.
13. FATHER'S NAME George W. Holdway		14. MOTHER'S MAIDEN NAME Polly Ann Dill	
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. Yes	17. INFORMANT Hollis Holdway, Beach, Missouri Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia Gangrene of lower extremities. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterial embolis, auricular fibrillation DUE TO (c) Cardial Mural Thrombi			INTERVAL BETWEEN ONSET AND DEATH 8 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Old Rheumatic fever (with Mitral Valvulitis)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from 5/2/57 to 5/10/57 and last saw her/him alive on 5/9/57 Death occurred at 9 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Andrew Martiniels, D.O.		22b. ADDRESS 700 E. Sunshine Springfield, Missouri	22c. DATE SIGNED 5/10/57
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 5-12-1957	23c. NAME OF CEMETERY OR CREMATORY THORPE	23d. LOCATION (City, town, or county) (State) DALLAS CO Mo.
24. FUNERAL DIRECTOR BARBER-EDWARDS MARSHFIELD ADDRESS		25. DATE RECD. BY LOCAL REG. 5-14-57	26. REGISTRAR'S SIGNATURE Wm. Williams

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.

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.....
Rev. Baska

Licensed Embalmer No. *38*

P. O. Address *Wm. Crane*

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.