

Dr. Fitch

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH24121
STATE FILE NUMBER

FILED AUG 12 1957

Registration District No. 128

Primary Registration District No. 2070

Registrar's No. 761-B

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dicator, coroner, etc. must be casually related. Coroner cannot certify to a death due to natural causes. diseases in Part I must be casually related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) 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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Limbrough Rest Home			Length of stay in 1b. 35 Yrs.		d. STREET ADDRESS 1041 W. Scott		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First CHARLES Middle A. Last BALAND				4. DATE OF DEATH Month July Day 27 Year 1957					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 18 1871		9. AGE (In years last birthday) 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Street Dept.			10b. KIND OF BUSINESS OR INDUSTRY City		11. BIRTHPLACE (City and state or country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles Baland				14. MOTHER'S MAIDEN NAME Sarah Hunter					
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. 500-05-7838		17. INFORMANT Address Archie Baland 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) Carcinoma of Head of Pancreas							INTERVAL BETWEEN ONSET AND DEATH NOT KNOWN		
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? 2 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.)						
20c. TIME OF INJURY Hour _____ 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 7-8-57 to 7-8-57 and last saw her/him alive on 7-8-57 Death occurred at 7:50 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Max Holt M.D. (Degree or title)			22b. ADDRESS 1715 BOONVILLE Springfield Missouri			22c. DATE SIGNED 8-2-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/30/57		23c. NAME OF CEMETERY OR CREMATORY Maple Park		23d. LOCATION (City, town, or county) (State) Springfield, Mo.			
24. FUNERAL DIRECTOR H.H. Lohmeyer ADDRESS Springfield, Mo.				25. DATE RECD. BY LOCAL REG. 8-5-57		26. REGISTRAR'S SIGNATURE Edith Williams			

(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 *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**. (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.