

Health, Public Service

FILED AUG 5 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2 000

2A187

STATE FILE NUMBER

Registration District No. 128

Primary Registration District No.

Registrar's No. 593-D

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-57

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| 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) Springfield | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Springfield 0396 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) 2332 Concord Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|-------------------------------|---|---|--|---|--|
| 3. NAME OF DECEASED (Type or print) First ALFRED Middle LEE Last Mc FALL | | | 4. DATE OF DEATH JULY 3-1957 Month Day Year | | | |
| 5. SEX Male | 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 Sept 22-1878 | | 9. AGE (In years last birthday) 78 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Springfield Street Dept. Retired | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Wade Co. Mo. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |

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| 13a. FATHER'S NAME C. A. Mc Fall | | 13b. MOTHER'S MAIDEN NAME Elizabeth Montgomery | | 14. NAME OF HUSBAND OR WIFE Nettie Mc Fall | |
| 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. 500-10-0707 | | 17. INFORMANT Nettie Mc Fall 2332 Concord - Springfield - Mo. Address | |

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| 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 Thrombosis | | INTERVAL BETWEEN ONSET AND DEATH 6 days 2 yr |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Cerebral Arteriosclerosis | |
| | DUE TO (c) | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma Prostate 332XH | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 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. Month, Day, Year _____ | | |

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|--|--|------------------------------|--------|-------|
| 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 **2-20-54** to **7-3-57** and last saw her alive on **7-3-57**
Death occurred at **11:40 a.m.** on the date stated above; and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE Paul C. Morton M.D. (Degree or title) | 22b. ADDRESS 1630 N. Jefferson Sprng. office Mo. | 22c. DATE SIGNED 7-5-57 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE July 5-57 | 23c. NAME OF CEMETERY OR CREMATORY Sycamore Cemetery | 23d. LOCATION (City, town, or county) (State) Springfield Missouri |
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| 24. FUNERAL DIRECTOR Brown - Daniel - Ash Grove, Mo. | 25. DATE RECD. BY LOCAL REG. 7-29-57 | 26. REGISTRAR'S SIGNATURE Edith Williamson |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *Doyle L. Sawyer*

Licensed Embalmer No. *4702*
P. O. Address *Adel Grove*

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.