

FILED SEP 3 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28014
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 841

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Springfield</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1662 E. Trafficway Life</u>		d. STREET ADDRESS (If outside, give location) <u>1662 E. Trafficway</u>	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Elizabeth</u> Last <u>Hale</u>			4. DATE OF DEATH Month <u>August</u> Day <u>26</u> Year <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 30, 1867</u>
9. AGE (In years last birthday) <u>89</u>		IF UNDER 1 YEAR Months <u>23</u> Days <u>17</u>	IF UNDER 24 HRS. Hours <u>3</u> Min. <u>48</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Springfield, Mo.</u>
13a. FATHER'S NAME <u>Willis Forbis</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Chadwell</u>	14. NAME OF HUSBAND OR WIFE <u>John Hale</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Homer Hale--Springfield, Missouri</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Circulatory failure.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Prolonged recumbency necessitated by traumatic injury to left hip.</u>			<u>19 days</u>
DUE TO (c) <u>Arteriosclerosis.</u>			<u>9030</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>20</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>Fell on floor at her home. With possible fracture of the hip.</u>	
20c. TIME OF INJURY Hour <u>12:15</u> Month, Day, Year <u>8-6-57</u>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>In her home.</u>	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <u>Springfield</u> COUNTY <u>Greene</u> STATE <u>Missouri</u>	
21. I attended the deceased from <u>Aug. 6</u> <u>11:00 p.</u> to <u>Aug. 25</u> and last saw her alive on <u>Aug. 6, 1957</u> Death occurred at <u>8/26/57</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>E. L. Williams, D.O.</u>		22b. ADDRESS <u>Springfield, Mo.</u>	
22c. DATE SIGNED <u>8-28-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-28-1957</u>	
23c. NAME OF CEMETERY OR CREMORY <u>Hazelwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>	
24. FUNERAL DIRECTOR <u>Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-28-57</u>	
26. REGISTRAR'S SIGNATURE <u>E. L. Williams</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

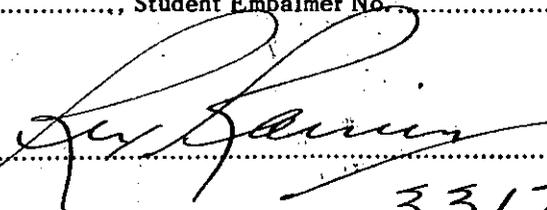
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

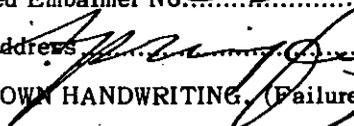
STATEMENT BY LICENSED EMBALMER

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 

Licensed Embalmer No. 3312

P. O. Address 

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.