

FILED AUG 19 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28018

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 792-B

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Greene</u>				a. STATE <u>Missouri</u>		b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only)		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Springfield</u>		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>Handley Hospital</u>		Length of stay in 1b <u>Yrs</u>		d. STREET ADDRESS <u>429 W. Chase</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>HARVEY</u> Middle <u>SYLVESTER</u> Last <u>HOUSE</u>				Month <u>August</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 22, 1885</u>	
9. AGE (In years last birthday) <u>72</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Lewis County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Johnny House</u>				14. MOTHER'S MAIDEN NAME <u>Mary Mumford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>John Ryan 630 Bell, Springfield</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>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Generalized Arteriosclerosis</u>					
		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? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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 _____							
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 <u>8-7-57</u> , to <u>same</u> and last saw ^{me} him alive on <u>11 AM 8-7-57</u> Death occurred at <u>1:00 p.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Albert P. Simpson, M.D.</u> (Degree or title)				22b. ADDRESS <u>301 Springfield Med. Bldg. Springfield, Mo.</u>		DATE SIGNED <u>8-13-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-12-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hazelwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>AYRE-GOODWIN, Inc. Springfield</u>			25. DATE RECD. BY LOCAL REG. <u>8-13-57</u>		26. REGISTRAR'S SIGNATURE <u>Robert Williamson</u>		

(Licensed Embalmer's Statement on Reverse Side)

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Lucien T. Swadley*

Licensed Embalmer No. 74

P. O. Address *Spring*

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.