

Health, Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 30 1957

31529
STATE FILE NUMBER
Registration District No. 128 Primary Registration District No. 5465 Registrar's No. 922

300
-57

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) OR TOWN N. Campbell Township		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN Springfield		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sunshine Acres		Length of stay in lb 5 mo.		d. STREET ADDRESS (If outside, give location) 2103 N. Taylor		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Rosa Middle Mable Last Marler				4. DATE OF DEATH Month Sept. Day 22 Year 1957				
5. SEX Female	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 Sept. 24, 1877		9. AGE (In years last birthday) 79	10. UNDER 1 YEAR Months 9 Days 15	11. UNDER 24 HRS. Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME (Doctor is name) Doctor Franklin Mallard			13b. MOTHER'S MAIDEN NAME Sarah Jane Carter			14. NAME OF HUSBAND OR WIFE Samuel Marler		
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. None		17. INFORMANT (son) Address Rual Miller-Springfield, Missouri.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia							INTERVAL BETWEEN ONSET AND DEATH 7 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Apoplexy				Interval 10 months		
		DUE TO (c) Arterial sclerosis				Interval 1 year		
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"/>	
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.) 334x					
20c. TIME OF INJURY Hour 3:34 Month, Day, Year a.m. 3 p.m. 4								
20d. INJURY OCCURRED WHILE AT <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 Aug 1, 1957 to Sept 22, 1957 and last saw her alive on Sept 22, 1957 Death occurred at Sept 22, 1957 2:15 p. m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE O. C. Horst (Degree or title) M.D.				22b. ADDRESS 430 South Ave Springfield Mo		22c. DATE SIGNED 9/24/1957		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-24-1957	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town, or county) Springfield, Missouri (State)			
24. FUNERAL DIRECTOR Sammy ADDRESS Springfield, Mo.			25. DATE RECD. BY LOCAL REG. 9-26-57		26. REGISTRAR'S SIGNATURE Edwin Williams			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

SEP 30 1951

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 *[Signature]*

Licensed Embalmer No. 3317

P. O. Address *[Signature]*

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.