

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35422

STATE FILE NUMBER

FILED NOV 4 1957

Registration District No.

128

Primary Registration District No.

2000

Registrar's No.

1060

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		c. CITY OR TOWN <b>Springfield</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Burge Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>2143 N. Johnston</b>	
Length of stay in lb <b>38 Yrs.</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>EVERETT</b> Middle <b>W.</b> Last <b>ENGLAND</b>			4. DATE OF DEATH Month <b>October</b> Day <b>31</b> Year <b>1957</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>21 Aug. 1896</b>	9. AGE (In years last birthday) <b>61</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Upholsterer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Upholstery Shop</b>	11. BIRTHPLACE (City and state or country) <b>Arkansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Isaac England</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Slover</b>	14. NAME OF HUSBAND OR WIFE <b>Mary England</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>	16. SOCIAL SECURITY NO. <b>491-03-978</b>	17. INFORMANT Address <b>Mary England Springfield, Mo.</b>
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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) <b>Old and acute massive myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cardiac necrosis + myocarditis, hemorrhagic</b>		
DUE TO (c) <b>4201</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c) <b>Chr. obliterative pericarditis, atelectasis left lung, acute passive congestion</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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
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21. I attended the deceased from <b>1-22-57</b> to <b>10-31-57</b> and last saw <sup>him</sup> <del>her</del> live on <b>10-31-57</b> Death occurred at <b>4:15 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>George L. Johnson, M.D.</b>	22b. ADDRESS <b>Springfield, Missouri</b>	22c. DATE SIGNED <b>11-1-57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-4-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or country) (State) <b>Springfield, Missouri</b>
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24. FUNERAL DIRECTOR <b>W. Keingner &amp; Co.</b>	ADDRESS <b>Spfgd. Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>11-1-57</b>	26. REGISTRAR'S SIGNATURE <b>Earl Williamson</b>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

17

RECEIVED  
 DEPARTMENT OF HEALTH  
 SPRINGFIELD, MASSACHUSETTS  
 NOV 8 1957  
 NOV 5 1957  
 NOV 12 1957  
 APR 10 1958  
 STATE OF MASSACHUSETTS  
 DEPARTMENT OF HEALTH  
 SPRINGFIELD, MASSACHUSETTS  
 RECEIVED  
 DEPARTMENT OF HEALTH  
 SPRINGFIELD, MASSACHUSETTS

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 \_\_\_\_\_

Signed Glen D. Williams

Signature of Student Embalmer

Licensed Embalmer No. 4651

P. O. Address Springfield

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.