

st. Health,  
, & Welfare  
S. Public  
th Service

THE DEPARTMENT OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

35457

STATE FILE NUMBER

FILED NOV 13 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1078

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Greene County</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, Mo.</u>		c. CITY OR TOWN <u>Springfield</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1610 N. Sherman</u>		d. STREET ADDRESS (If outside, give location) <u>1610 N. Sherman</u>	
Length of stay in lb <u>29 yrs.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Ellis</u> Middle <u>Loren</u> Last <u>Logan</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>5</u> Year <u>1957</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1888</u>	9. AGE (In years at birthday) <u>69</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales manager retired</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>grocery</u>	11. BIRTHPLACE (City and state or country) <u>Marionville, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
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13a. FATHER'S NAME <u>W. A. B. Logan</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Grubaugh</u>	14. NAME OF HUSBAND OR WIFE <u>Gertrude Logan</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT <u>Mrs. L. Logan, Springfield, Mo.</u>	Address <u></u>
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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) <u>Inanition and debilitation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chron. Lymphoid Leukemia</u>	<u>over 3 months</u>
	DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Myocardial Decompensation</u>		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

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.) <u></u>
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20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>	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.) <u></u>	20f. CITY, TOWN, OR LOCATION <u></u>	COUNTY <u></u>	STATE <u></u>
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21. I attended the deceased from <u>Dec 1953</u> to <u>11-5-57</u> and last saw <sup>her</sup> him alive on <u>11-5-57</u> Death occurred at <u>4:10 am</u> 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) <u>D. L. Williams, M.D.</u>	22b. ADDRESS <u>Springfield, Missouri</u>	22c. DATE SIGNED <u>11-5-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>Nov. 5, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I. O. O. F. Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Marionville, Mo.</u>
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24. FUNERAL DIRECTOR <u>J. B. Surridge</u>	ADDRESS <u>Marionville Mo</u>	25. DATE RECD. BY LOCAL REG. <u>11-7-57</u>	26. REGISTRAR'S SIGNATURE <u>Edith Williams</u>
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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

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 *William A. Fielke*

Licensed Embalmer No. *4658*

P. O. Address *Marionville*

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.