

FILED NOV 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35479

STATE FILE NUMBER

Registration District No. 128

Primary Registration District No. 200e

Registrar's No. 1043

5. 300

1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Polk	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Halfway
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital		Length of stay in 1b 2 days	d. STREET ADDRESS (If outside, give location) HALFWAY
3. NAME OF DECEASED (Type, or print) First EUGENE Middle DANIEL Last MOINE			4. DATE OF DEATH Month October Day 25 Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Arlington, Iowa
13a. FATHER'S NAME Moine		13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year dates of service) no		16. SOCIAL SECURITY NO. -----	17. INFORMANT Address Jaunita Pettit, Racina, California
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic coronary thrombosis			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Senile arteriosclerosis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201			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.)	
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
21. I attended the deceased from Oct 18, 1957 to Oct 25, 1957 and last saw him alive on 10-25-57 Death occurred at 9:15 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) Harold B. Huson MD		22b. ADDRESS Springfield, Mo	22c. DATE SIGNED 10-26-57
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE Oct. 27, 1957	23c. NAME OF CEMETERY OR CREMATORY Unknown	23d. LOCATION (City, town, or county) (State) Torrington, Wyoming
24. FUNERAL DIRECTOR Ralph Thieme, Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 10-29-57	26. REGISTRAR'S SIGNATURE Edith Williamson

SEP 9 1958

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 *Le Mason*

Licensed Embalmer No. *4568*
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.