

r. Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39916

STATE FILE NUMBER

FILED DEC 9 - 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1149-A

S. 300  
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>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Connelly Nursing 1330 Cherry</b>		d. STREET ADDRESS <b>2058 N. Grant</b>	
Length of stay in 1b <b>40yrs.</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lucy E. Chumbley</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>27</b> Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 9, 1874</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (In years birthday) <b>83</b>
11. BIRTHPLACE (City and state or country) <b>Bentonville, Ark.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Henry Clay Wester</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Ben Chumbley</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT (Dau.) Address <b>Mrs. Earl Anderson-Springfield, Mo.</b>
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>Coronary thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b>			
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"/>
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.) <b>4201</b>	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 <b>September 1957</b> to <b>November 5, 1957</b> last saw her alive on <b>20 November 1957</b> Death occurred at <b>7:30 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Karl J. Leidinger, Jr. M.D.</b>		22b. ADDRESS <b>Republic, Mo</b>	22c. DATE SIGNED <b>11-29-57</b>
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov. 29 - '57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Republic, Missouri</b>
24. FUNERAL DIRECTOR <b>Garvin</b>		ADDRESS <b>Springfield, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>12-3-57</b>
			26. REGISTRAR'S SIGNATURE <b>Walter Williams</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

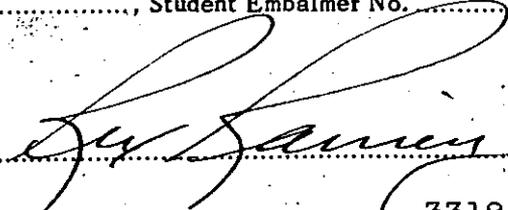
MEDICAL CERTIFICATION

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.

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  .....

Licensed Embalmer No. 3312

P. O. Address Springfield, Mo

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.