

Phys. Health,  
, & Welfare  
S. Public  
with Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33334  
STATE FILE NUMBER

FILED DEC 13 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1172

S. 300  
ev. 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 <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>313 1/2 College St.</b>		Length of stay in lb <b>40 yrs.</b>	d. STREET ADDRESS <b>313 1/2 College St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LLOYD</b> Middle <b>B.</b> Last <b>FAUGHT</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>7</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 26, 1910</b>	9. AGE (In years last birthday) <b>47</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Albert Faught</b>		13b. MOTHER'S MAIDEN NAME <b>Lona Herndon</b>		14. NAME OF HUSBAND OR WIFE <b>Divorced</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give yrs or dates of service) <b>Yes WW2</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Brighton, Mo</b> <b>Lenza Faught (Brother)</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>Likely Alcoholism</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to 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>UNATTENDED BY A PHYSICIAN</b>			
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 _____ Death occurred at <b>About 11:55 pm</b> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>James P. Amos, M.D.</b> (Degree or title) <b>Health Officer</b>		22b. ADDRESS <b>Greene County Health Dept.</b>		22c. DATE SIGNED <b>12-10-57</b>	
23a. BURIAL, CREMATION, GENERAL (Specify) <b>Burial</b>	23b. DATE <b>12-12-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Mo.</b>		
24. FUNERAL DIRECTOR <b>J.W. Klingner &amp; Co.</b>		ADDRESS <b>Spfld, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>12-10-57</b>	26. REGISTRAR'S SIGNATURE <b>Edith Williamson</b>	

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

(Licensed Embalmer's Statement on Reverse Side)

DEC 18 1957

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 *Ogle Stone Jr* .....

Licensed Embalmer No. *4176* .....  
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.