

FILED NOV 25 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1108

5. 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> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <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>Burge Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>2222 N. Missouri</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>C.</b> Last <b>TOALSON</b>		4. DATE OF DEATH <b>November 15, 1957</b> Month Day Year	
5. SEX <b>Female</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>27 Sept. 1896</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>	11. BIRTHPLACE (City and state or country) <b>Oklahoma</b>
13a. FATHER'S NAME <b>S. MORRIS</b>		13b. MOTHER'S MAIDEN NAME <b>BETTY STARKEY</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>No</b> (If yes, give war & dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>	17. INFORMANT Address <b>Hospital Records</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>Acute purulent bronchopneumonia</b> <b>Both recent and old</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Myocardial infarction of intraventricular septum moderate to severe coronary artery disease</b> DUE TO (c) <b>and with almost complete occlusion of anterior descending coronary</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 days</b> <b>Probably two years</b> <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <b>Cerebral Atrophy due to basilar artery embolus</b>			19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input 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 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.)	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>11-9-57</b> to <b>11-15-57</b> and last saw her alive on <b>11-15-57 10 pm</b> Death occurred at <b>10:49 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Albert P. Simpson, M.D.</b>		22b. ADDRESS <b>1630 N. Jefferson Springfield, Missouri</b>	22c. DATE SIGNED <b>11-19-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or country) (State)
<b>Burial</b>	<b>11-18-57</b>	<b>Greenlawn</b>	<b>Springfield, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>J. Klingner &amp; Co. Spgfd. Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-20-57</b>	26. REGISTRAR'S SIGNATURE <b>Wm. Williams</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

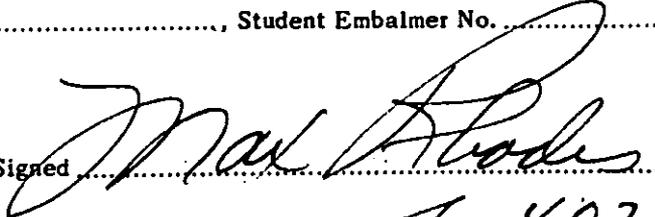
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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. 4071  
P. O. Address .....

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.