

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40025

STATE FILE NUMBER

FILED DEC 2 - 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1144

S. 300
1-57 0

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY (If outside, give location) OR TOWN Springfield	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital		d. STREET ADDRESS (If outside, give location) 2224 N. Weller	

3. NAME OF DECEASED (Type or print) First MARK Middle LANCE Last WESTERN			4. DATE OF DEATH: Month November Day 25 , Year 1957		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 Nov. 1957	9. AGE (In years last birthday) 0	IF UNDER 1 YEAR Months 0 Days 1	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY Infant	11. BIRTHPLACE (City and state or country) Springfield, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John C. Western	13b. MOTHER'S MAIDEN NAME Margaret Pilkington	14. NAME OF HUSBAND OR WIFE None
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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) No	16. SOCIAL SECURITY NO. No	17. INFORMANT Hospital Records	Address
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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) sub arachnoid hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 1 day.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) terminal tear.	
	DUE TO (c) difficult labor	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease, condition given in PART I (a) 7600		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. 	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION	COUNTY	STATE
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20f. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20g. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20h. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from **11-24-57** to **11-25-57** and last saw ~~him~~ ^{her} alive on **11-25-57**
Death occurred at **8:00 A.M.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) David D. Thomason M.D.	22b. ADDRESS 1630 N. Jefferson Springfield, Missouri	22c. DATE SIGNED 11-27-57
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23a. BURIAL, CREMATION, or other (specify) Burial	23b. DATE 11-26-57	23c. NAME OF CEMETERY OR CREMATORY Greenlawn	23d. LOCATION (City, town, or county) (State) Springfield, Missouri
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24. FUNERAL DIRECTOR Jawkingner & Co.	ADDRESS Spfld. Mo.	25. DATE RECD. BY LOCAL REG. 11-29-57	26. REGISTRAR'S SIGNATURE Edna Williams
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(Licensed Embalmer's Statement on Reverse Side)

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

Signed

Signature of Student Embalmer

Licensed Embalmer No.

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.