

pt. Health,
, & Welfare
S. Public
lth Service

Turner

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40030
STATE FILE NUMBER

FILED NOV 18 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1094

S. 300
ev. 1-57

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) Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 821 E. Catalpa		Length of stay in 1b 40 yrs.	d. STREET ADDRESS (If outside, give location) 821 E. Catalpa		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALONZO Middle NEWTON Last WISE			4. DATE OF DEATH Month November Day 10 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 21 Aug.		9. AGE (In years last birthday) F UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Feed Dealer		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Cora Wise	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give war and dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Cora Wise Springfield, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTEROSCLEROTIC HEART DISEASE WITH SEVERAL MRS CONGESTIVE FAILURE (CARDIAC INSUFFICIENCY)					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) _____					4200
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) NEURODERMATITIS, GENERALIZED, SEVERE.					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 7-3-57 to 11-10-57 and last saw him alive on 11-10-57 Death occurred at 7:10 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Alonzo T. Turner</i> (Degree or title)		22b. ADDRESS 609 Cherry M.D. Springfield, Missouri		22c. DATE SIGNED 11-12-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-12-57		23c. NAME OF CEMETERY OR CREMATORY Maple Park	
		23d. LOCATION (City, town, or county) Springfield, Mo.		(State)	
24. FUNERAL DIRECTOR <i>John Klugner & Co.</i> ADDRESS Spfgd. Mo.		25. DATE RECD. BY LOCAL REG. 11-14-57		26. REGISTRAR'S SIGNATURE <i>John Williamson</i>	

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.

November 10, 1958
 State of Georgia
 Springdale, Mo.
 No. 4651
 P. O. Address
 Licensed Embalmer No. 4651
 Signature of Student Embalmer
 Student

MAR 24 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 _____ Signed Glen D. Williams
 Signature of Student Embalmer
 Licensed Embalmer No. 4651
 P. O. Address Springdale, 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.