

Health,
& Welfare
S. Public
Service

S. 300
1-57

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.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 30 1957

44050
STATE FILE NUMBER
1217

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1217

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 Springfield TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield ²³⁴⁰ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Handley Hosp.		Length of stay in 1b 6 days	d. STREET ADDRESS (If outside, give location) 1940 W. Atlantic Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle R. Last Haley			4. DATE OF DEATH Month Dec. Day 19 Year 1957
5. SEX Male <input type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1868
9. AGE (In years last birthday) 89		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail-carrier		10b. KIND OF BUSINESS OR INDUSTRY Postal	11. BIRTHPLACE (City and state or country) Iowa
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13a. FATHER'S NAME Joab Haley		13b. MOTHER'S MAIDEN NAME Mary Jane Harrison	14. NAME OF HUSBAND OR WIFE Ida F. Haley
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. None	17. INFORMANT Address Pearl Derks--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) Cerebral apoplexy			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 the terminal disease condition given in PART I (a) 334x			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 Dec. 13, 1957 to Dec. 19 and last saw him alive on Dec. 19, 1957 . Death occurred at 10:30 a. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Lyman D. Brown M.D.		22b. ADDRESS 311 1/2 College	22c. DATE SIGNED 12/20/57
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-22-1957	23c. NAME OF CEMETERY OR CREMATORY Arroll Cemetery	23d. LOCATION (City, town, or county) (State) Arroll, Missouri
24. FUNERAL DIRECTOR ADDRESS Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 12-20-57	26. REGISTRAR'S SIGNATURE T. W. Williamson

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

DEC 30 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 _____

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.