

Dept. Health,  
c., & Welfare  
S. Public  
alth Service

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

FILED DEC 23 1957

44062  
STATE FILE NUMBER  
1210  
Registrar's No.

Registration District No. 128 Primary Registration District No. 2000

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>		c. CITY OR TOWN <b>Springfield</b> <sup>2396</sup>	
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>1206 E. Commerical</b>	
Length of stay in lb <b>73 Yrs.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>ISREAL</b> Last <b>ISREAL</b>			4. DATE OF DEATH <b>Dec. 17, 1957</b>		
--	--	--	---------------------------------------	--	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 24, 1884</b>	9. AGE (In years last birthday) <b>73</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
----------------------	-------------------------------	--	---------------------------------------	---	--	--

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>In Home</b>	11. BIRTHPLACE (City and state or country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--	--	--	---

13a. FATHER'S NAME <b>Stover</b>	13b. MOTHER'S MAIDEN NAME <b>Unk.</b>	14. NAME OF HUSBAND OR WIFE <b>Widow</b>
----------------------------------	---------------------------------------	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>486-30-4080</b>	17. INFORMANT <b>Mrs. Ruby Morelock Spfld. Mo.</b>	Address
---	--	--	---------

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>Bronchogenic Carcinoma (Right)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic Heart Disease</b>	<b>4 Months</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)		19. WAS AUTOPSY PERFORMED? <b>NO</b> <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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____
---	--	---

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 <b>9-30-57</b> to <b>12-17-57</b> and last saw <sup>her</sup> him alive on <b>12-16-57</b> Death occurred at <b>4:30 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <i>[Signature]</i> (Degree or title) <b>0</b>	22b. ADDRESS <b>1630 N. Jefferson</b>	22c. DATE SIGNED <b>12-17-57</b>
--	---------------------------------------	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-20-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Comfort Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Greene Co. Missouri</b>
---	---------------------------	--	--

24. FUNERAL DIRECTOR <i>[Signature]</i> ADDRESS <b>Spfld. Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>12-18-57</b>	26. REGISTRAR'S SIGNATURE <b>Edith Williamson</b>
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

K.F.

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

V. S. 300  
Rev. 1-57

