

FILED JAN 6 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1248

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

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		c. CITY OR TOWN Springfield <u>0344</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) St. John's Hosp.		d. STREET ADDRESS (If outside, give location) 1453 Luster Dr.	
Length of stay in lb HOSPITAL OR INSTITUTION 17 Yrs.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle L. Last LOUGHLIN			4. DATE OF DEATH Month Dec. Day 30 Year 1957
5. SEX Male	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. 13 1920
9. AGE (In years last birthday) 37	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Exchange Repairman	11. BIRTHPLACE (City and state or country) Bison, S.D.	12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Exchange Repairman	10b. KIND OF BUSINESS OR INDUSTRY S.W. Bell Tel. Co.	11. BIRTHPLACE (City and state or country) Bison, S.D.	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Charles Loughlin		13b. MOTHER'S MAIDEN NAME Grace Kruse	
14. NAME OF HUSBAND OR WIFE Charlene Loughlin		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, type or unknown) (If yes, give year or dates of service) Yes W.W. # 2	
16. SOCIAL SECURITY NO. 321-12-7098		17. INFORMANT Address Mrs. Charlene Loughlin Spfld, 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) Peritonitis, acute			INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Atelectasis & pneumonia			2 days
DUE TO (c) Cholecystitis with cholelithiasis			1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Shock.			19. WAS AUTOPSY PERFORMED? YES 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.) 584X	
20c. TIME OF INJURY .Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 12/24/57 to 12/30/57 and last saw him alive on 12/30/57 Death occurred at 3:30 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Chas E Lockhart MD (Dee or title)		22b. ADDRESS 609 Cherry St	22c. DATE SIGNED 12/31/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/2/58	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Springfield, Mo.
24. FUNERAL DIRECTOR H.H. Lohmeyer		ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 12-31-57
26. REGISTRAR'S SIGNATURE Edith Williams			

JAN 13 1958

JAN 9 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
Signature of Student Embalmer

Signed

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.