

FILED DEC 23 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1195

V. S. 300
Rev. 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) OR TOWN Springfield		c. CITY OR TOWN Springfield <u>039A</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) HOSPITAL OR INSTITUTION 901 N. Kansas		d. STREET ADDRESS (If outside, give location) 901 N. Kansas	
Length of stay in lb 74 Yrs.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE E. MASSEY			4. DATE OF DEATH Month Day Year Dec. 14 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 Aug. 26 1883
9. AGE (In years last birthday) 74		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) Retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	11. BIRTHPLACE (City and state or country) Springfield, Mo.
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Richard Massey	
13b. MOTHER'S MAIDEN NAME Hannah Pryor		14. NAME OF HUSBAND OR WIFE Gussie Massey	
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 Mrs. Gussie Massey		Address 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) <u>Cerebral Hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis generalised</u>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Paral. of legs 39 years duration</u>			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.) <u>—</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <u>6 a.m.</u>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	
20e. CITY, TOWN, OR LOCATION <u>—</u>		COUNTY STATE	
20f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20g. CITY, TOWN, OR LOCATION <u>—</u>	
20h. COUNTY		STATE	
21. I attended the deceased from <u>14 December 57 Only</u> and last saw ^{her} him alive on <u>14 Dec 1957</u> Death occurred at <u>6 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Stanley Peterson M.D.</u> (Degree or title)		22b. ADDRESS <u>Springfield, Mo</u>	
22c. DATE SIGNED <u>17 Dec 1957</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/17/57	
23c. NAME OF CEMETERY OR CREMATORY Maple Park		23d. LOCATION (City, town, or county) Springfield, Mo.	
24. FUNERAL DIRECTOR H.H. Lohmeyer		ADDRESS Springfield, Mo.	
25. DATE RECD. BY LOCAL REG. 12-17-57		26. REGISTRAR'S SIGNATURE <u>Edith Williamson</u> K. G.	

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

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 *W. L. McCann*

Licensed Embalmer No. *2727*

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.