

STANDARD CERTIFICATE OF DEATH

FILED DEC 23 1957

Registration District No. 128 Primary Registration District No. 300 Registrar's No. 1175-A

V. S. 300
Rev. 1-57
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1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dallas	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Fairgrove RR	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION The Way to Springfld Mo		d. STREET ADDRESS (If outside, give location) 34 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last DOSHEY BELLE SLATER	4. DATE OF DEATH Month Day Year 12-7-1957
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5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-1887	9. AGE (In years last birthday) 70	IF FUNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most working year, even if retired) Crosschecker	10b. KIND OF BUSINESS OR INDUSTRY Queen Home	11. BIRTHPLACE (City and state or country) Dallas Co Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Mitchell Higginfill	13b. MOTHER'S MAIDEN NAME Nettie Martini	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ?	16. SOCIAL SECURITY NO. ?	17. INFORMANT Address Clyde Slater Red Top Mo
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dead from internal injuries to face, chest and broken leg		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Dead on arrival at Hospital	
	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? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input checked="" 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.) Car accident on Jan to Market RR 1 mile S Olin
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20c. TIME OF INJURY Hour Month, Day, Year 11:30 p.m. 12-8-57	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 39 COUNTY Greene STATE Mo
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 5:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) L. B. Jones Coroner 3	22b. ADDRESS Buffalo Mo	22c. DATE SIGNED 12-9-57
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-11-1957	23c. NAME OF CEMETERY OR CREMATORY Met Oline	23d. LOCATION (City, town, or county) (State) Dallas Co Mo
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24. FUNERAL DIRECTOR L B Jones	ADDRESS Buffalo Mo	25. DATE RECD. BY LOCAL REG. 12-17-57	26. REGISTRAR'S SIGNATURE Edith Williamson
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(Licensed Embalmer's Statement on Reverse Side)

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

JUN 18 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 *L. J. Jones*
Licensed Embalmer No. *2500*

P. O. Address *Buffalo, N.Y.*

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.