

Health, Welfare  
Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-005096  
STATE FILE NUMBER

FILED MAR 3 - 1958

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 190

300  
-57

4

1. PLACE OF DEATH a. COUNTY <b>Greene</b>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>Dallas</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD, MO</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Purel - Lincoln</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (In hospital or institution) <b>CYNTHIA ANN DARBY</b>		Length of stay in hospital or institution <b>5 months</b>	d. STREET ADDRESS (If outside, give location) <b>3048 Puffin Rest Home</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Cynthia</b> Middle <b>ANN</b> Last <b>Darby</b>			4. DATE OF DEATH Month <b>2</b> Day <b>23</b> Year <b>58</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct-7-1872</b>	9. AGE (In years last birthday) <b>85</b>	FUNDER YEAR Months <b>3</b> Days <b>16</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
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>Home</b>	11. BIRTHPLACE (City and state or country) <b>Hickory Co, MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>
13a. FATHER'S NAME <b>James F. Lindsey</b>		13b. MOTHER'S MAIDEN NAME <b>Eliza A. Montgomery</b>		14. NAME OF HUSBAND OR WIFE <b>Albert Darby</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>	17. INFORMANT Address <b>Luther Brown Urbana MO</b>		
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>Pneumonia, bilateral terminal</b> DUE TO (b) <b>Flu</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>12 hr</b> <b>2 days</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the terminal disease condition given in PART I (a)) <b>Arthritis, generalized</b>					19. WAS AUTOPSY PERFORMED? <b>2</b> 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 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 <b>Nov. 1957</b> to <b>Feb 23, 1958</b> and last saw her alive on <b>2-23-58</b> Death occurred at <b>12:15 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>M. L. Gentry M.D.</b>			22b. ADDRESS <b>Med Arts Bldg. Spfld. Mo</b>		22c. DATE SIGNED <b>2-25-58</b>
23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>BURIAL</b>	23b. DATE <b>2-26-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bowers Chapel Co</b>		23d. LOCATION (City, town, or country) (State) <b>Dallas Co MO</b>	
24. FUNERAL DIRECTOR <b>Allen W. Vaughan</b>		ADDRESS <b>Urbana Mo</b>		25. DATE RECD. BY LOCAL REG. <b>2-27-58</b>	26. REGISTRAR'S SIGNATURE <b>Effie G. Melton</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Allen W. Vaughan* .....

Licensed Embalmer No. *4156*.....  
P. O. Address *Ypsilanti, mi*.....

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.