

Dr. Purcell
FILED MAR 3 - 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005106

STATE FILE NUMBER

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 198

300
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 Texas	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Mt. Grove	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hosp.		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First JOSEPH Middle E. Last EARL			4. DATE OF DEATH Month Feb. Day 26 Year 1958		
--	--	--	--	--	--

5. SEX Male	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 Aug. 28 1886	9. AGE (In years) 71	F 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) Retired Clerk	10b. KIND OF BUSINESS OR INDUSTRY Frisco R.R.	11. BIRTHPLACE (City and state or country) Arkansas	12. CITIZEN OF WHAT COUNTRY? USA
---	---	---	--

13a. FATHER'S NAME James Earl	13b. MOTHER'S MAIDEN NAME Roseann Main	14. NAME OF HUSBAND OR WIFE X
---	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. ?	17. INFORMANT Leavon Julian	Address Mt. Grove, 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) Probable cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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? 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.) 332X
---	---

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 2-25-58 to 2-26-58 and last saw her/him alive on 2-26-58 Death occurred at 9:07 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Em Purcell, M.D.	(Degree or title) 0	22b. ADDRESS 307 Professional Bldg, Springfield, Mo.	22c. DATE SIGNED 2-28-58
---	----------------------------	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/28/58	23c. NAME OF CEMETERY OR CREMATORY Friendship Cem.	23d. LOCATION (City, town, or county) (State) Near Mt. Grove, Mo.
--	-----------------------------	--	---

24. FUNERAL DIRECTOR H.H. Lohmeyer	ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
--	------------------------------------	------------------------------	---------------------------

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

MAR 3 1058

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ^{not} ~~was~~ embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *W. M. C. Case*

Licensed Embalmer No. *2727*
P. O. *Springfield*

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.