

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

58-005111
 STATE FILE NUMBER 224

Dr. Turner

FILED MAR 10 1958

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

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 Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) Springfield		c. CITY OR TOWN Springfield	
c. FULL NAME OF (If NOT in hospital, give location) 610 E. Harrison		d. STREET ADDRESS 610 E. Harrison	
Length of stay in 1b 34 Yrs.		(If outside, give location) 246	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First ANNIE	Middle C.	Last GELVEN	Month March	Day 3	Year 1958

5. SEX Female	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. 18 1874	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
-------------------------	----------------------------------	---	---	--	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Mexico, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
---	-----------------------------------	--	--

13a. FATHER'S NAME William H.C. Diessel	13b. MOTHER'S MAIDEN NAME Mary Meyer	14. NAME OF HUSBAND OR WIFE Charles H. Gelven
---	--	---

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 Charles H. Gelven	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) Hypertension and Atherosclerosis Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 3 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertension, Essential		2 1/2 yr.
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 44 3X		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.)
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT 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 10-14-36 to 3-3-58 and last saw her ^{her} alive on 1-24-58 Death occurred at 1 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE [Signature]	(Degree or title) M.D.	22b. ADDRESS 609 Cherry-Springfield, Mo.	22c. DATE SIGNED 3-3-58
--------------------------------------	----------------------------------	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/5/58	23c. NAME OF CEMETERY OR CREMATORY St. Mary's 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. 3-4-58	26. REGISTRAR'S SIGNATURE [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.

YS JUL 19 1961

STATEMENT BY LICENSED EMBALMER

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

Student
Signature of Student Embalmer

Signed *H. H. McCann*

Licensed Embalmer No. *2727*
P. O. Address *Springfield, Mo.*

cust.

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.