

t. Health,
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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 by *W. J. ...*

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005148

STATE FILE NUMBER *89-B*

FILED FEB 17 1958

Registration District No. *128* Primary Registration District No. *2000* Registrar's No. *89-B*

| | | | | | | | |
|---|-------------------------------|--|---|--|---|---|--|
| 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 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN Houston | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Johns Hospital | | Length of stay in lb 11 days | | d. STREET ADDRESS (If outside, give location) No street address | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last LONNIE HERMAN MAY | | | | 4. DATE OF DEATH Month Day Year January 25, 1958 | | | |
| 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 checked="" type="checkbox"/> | | 8. DATE OF BIRTH Apr 20, 1889 | | 9. AGE (In years last birthday) 68 | 10. FUNDERS YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Butcher | | 10b. KIND OF BUSINESS OR INDUSTRY Retail Grocery | | 11. BIRTHPLACE (City and state or country) Wynbon, Mississippi | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13a. FATHER'S NAME John May | | | 13b. MOTHER'S MAIDEN NAME Martha Vaughn | | | 14. NAME OF HUSBAND OR WIFE -- | |
| 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. 411-30-5116 | | 17. INFORMANT Address Robert May, Licking, Missouri | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure | | | | | | INTERVAL BETWEEN ONSET AND DEATH 11 days | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) arteriosclerotic coronary artery disease | | | | DUE TO (c) 4201H | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Myasthenic obstruction secondary to cancer of sigmoid colon | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18-7) | | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | | | | | |
| 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 | | COUNTY STATE | |
| 21. I attended the deceased from 1/14/58 to 1/25/58 - and last saw him alive on 1/25/58 Death occurred at 1:00 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) Robert W. Maher - M. H. O. | | | | 22b. ADDRESS Professional Bldg, Springfield, Missouri | | 22c. DATE SIGNED 1/27/58 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE Jan 26, 1958 | 23c. NAME OF CEMETERY OR CREMATORY Unknown | | 23d. LOCATION (City, town, or county) (State) Houston, Missouri | | |
| 24. FUNERAL DIRECTOR Jewell E. Windle ADDRESS Springfield, Mo. | | | 25. DATE RECD. BY LOCAL REG. 2-11-58 | | 26. REGISTRAR'S SIGNATURE Effie G. Melton | | |

MAR 10 1958 FEB 19 1958

MAR 28 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 *Robert E. Mullman*

Licensed Embalmer No. *7916*
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.