

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH 91079-57

58-009586
STATE FILE NUMBER
350

FILED APR 7 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 350

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) OR TOWN Springfield		c. CITY OR TOWN Springfield ⁰³⁹⁶	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BOA Burge Hosp.		d. STREET ADDRESS (If outside, give location) 1423 N. LaFontain	
Length of stay in lb 3 Mo.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First RAYETTA Middle SUE Last PENDERGRASS			4. DATE OF DEATH Month March Day 31 Year 1958		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27 1957	9. AGE (In years last birthday) 3 Months 4 Days	IF UNDER 1 YEAR Hours 4 Min.	IF UNDER 24 HRS. Hours 4 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Springfield, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Chester Pendergrass	13b. MOTHER'S MAIDEN NAME Helen Altic	14. NAME OF HUSBAND OR WIFE X
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown)	16. SOCIAL SECURITY NO. No	17. INFORMANT Chester Pendergrass Address Springfield, 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) Probable Asphyxia Food - (milk) obstruction DUE TO (b) Unattended by a physician DUE TO (c) Unattended by a physician PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Brief
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.)
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20c. TIME OF INJURY Hour 1:33 Month, Day, Year	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 Springfield COUNTY Mo STATE
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21. I attended the deceased from _____ and last saw him _____ Death occurred on About 10 a.m. _____ m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE James R. Ames M.D. (Degree or title) 5	22b. ADDRESS Health Officer, Greene County Health	22c. DATE SIGNED 4-1-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-2-58	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cem.	23d. LOCATION (City, town, or county) (State) Springfield, Mo
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24. FUNERAL DIRECTOR H.H. Lohmeyer ADDRESS Springfield Mo.	25. DATE RECD. BY LOCAL REG. 4-1-58	26. EMBALMER'S SIGNATURE Offie S. Melton
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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

Licensed Embalmer No.

P. O. Address

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.