

FILED MAR 24 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-009609
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 200 Registrar's No. 278

300
-57

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Mt. Vernon</u> <u>0558</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mercy Hospital</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>Route 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>---</u> Last <u>Spalding</u>			4. DATE OF DEATH Month <u>Mar.</u> Day <u>14</u> Year <u>1958</u>		
---	--	--	--	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1863</u>	9. AGE (In years last birthday) <u>94</u>	FUNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
-------------------------	----------------------------------	---	---	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher-Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	11. BIRTHPLACE (City and state or country) <u>Miller County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
---	--	---	---

13a. FATHER'S NAME <u>John T. Gilleland</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Atkinson</u>	14. NAME OF HUSBAND OR WIFE <u>William V. Spalding</u>
--	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Arvil L. Spalding-Mt. Vernon, Mo.</u> Address _____
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suicidity</u>		INTERVAL BETWEEN ONSET AND DEATH
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"/> <u>2</u> <u>794X</u>

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 WORK <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 11-7-57, to 3-12-58 and last saw her alive on 3-12-58
Death occurred at 10:30 p. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>Springfield, Mo.</u>	22c. DATE SIGNED <u>3-15-58</u>
--	---	------------------------------------

23a. BURIAL, CREMATION, OR OTHER DISPOSAL <u>Burial</u>	23b. DATE <u>3-18-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Olean Cemetery</u>	23d. LOCATION (City, town, or county) <u>Miller County, Missouri.</u> (State)
--	-------------------------------	---	--

24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>Springfield, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3-21-58</u>	26. REGISTRAR'S SIGNATURE <u>Effie B. Melton</u>
--	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

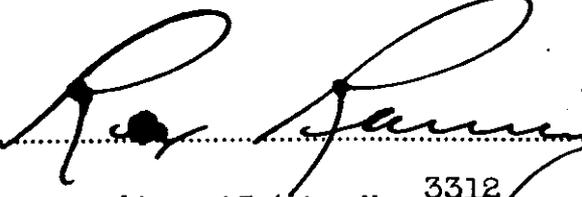
All diseases in Part I must be causally related.

MS JAN 5 1961

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. 3312

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.