

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013849

STATE FILE NUMBER

FILED APR 28 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 413

S. 300 0
1-57

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

1. PLACE OF DEATH a. COUNTY <u>Green</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wright</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Norwood</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ozark Osteopathic Hosp.</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>Route 1</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Alpha</u> Middle <u>Kelley</u> Last <u>Kelley</u>			4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>58</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/14/14</u>	9. AGE (In years last birthday) <u>43</u>	IF UNDER 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>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Norwood, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Clombus Cartwright</u>		13b. MOTHER'S MAIDEN NAME <u>Bessie Moore</u>		14. NAME OF HUSBAND OR WIFE <u>Floyd Kelley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>yes</u>	17. INFORMANT Address <u>Mr. Floyd Kelley, Rt. 1, Norwood, Mo.</u>		
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>Acute medullary failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Subarachnoid hemorrhage with increased intracranial pressure</u>					<u>27 days</u>
DUE TO (c) <u>Unknown</u>					<u>330X</u> <u>unknown</u>
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.)		
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 <u>3/23/58</u> to <u>4/17/58</u> and last saw her alive on <u>4/17/58</u> Death occurred at <u>8:40 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Andrew Martiniak, D.O., J.</u>			22b. ADDRESS <u>700 E. Sunshine Springfield, Missouri</u>		22c. DATE SIGNED <u>4/19/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4/20/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>WRIGHT Co., Mo.</u>	
24. FUNERAL DIRECTOR <u>John Simpson Hartwell</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>4-23-58</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 *George Slapp*

Licensed Embalmer No. *3161*

P. O. Address *Mt. Hope*

W. H. H.

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.