

Dr. Clarke

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-013904

STATE FILE NUMBER

FILED APR 28 1958

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 414

300  
1-57

1. PLACE OF DEATH. a. COUNTY <b>Greene</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <b>0396</b> a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Springfield</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2610 E. Belmont</b>		Length of stay in lb <b>48 Yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>2610 E. Belmont</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>WERKMASTER</b> Last <b>WERKMASTER</b>			4. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7 1873</b>	9. AGE (In years last birthday) <b>85</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Freeburg, Ill. 1</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Joseph Krieg</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Hineman</b>		14. NAME OF HUSBAND OR WIFE <b>Jpseph Werkmaster (Dec.)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT Address <b>Mrs. Chas. A. Miller Springfield, Mo</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Circulatory failure</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary insufficiency</b>					<b>1 hr</b>
DUE TO (c) <b>Arteriosclerosis generalized</b>					<b>20 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease, condition given in PART I (a) <b>4201</b>					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 <b>6:30</b> Month, Day, Year <b>April 18-58</b> a.m. p.m.			20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <b>6:30 a.m.</b> to <b>April 18-58</b> and last saw her alive on <b>April 18-1958</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Michael J. Clarke M.D.</b>			22b. ADDRESS <b>1636 S. Glenstone, Springfield, Missouri</b>		22c. DATE SIGNED <b>4-18-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4/21/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Springfield, Mo.</b>
24. FUNERAL DIRECTOR <b>H.H. Lohmeyer</b>		ADDRESS <b>Springfield, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>4-22-58</b>	26. REGISTRAR'S SIGNATURE <b>Offie G. Melton</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JUL 28 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 *A. L. McCann* .....

Licensed Embalmer No. *2727* .....

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.