

Dr. Tsang
H. Lohmeyer

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-021611
STATE FILE NUMBER

FILED JUN 16 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 582 B

300
-57

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1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pulaski	
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 Waynesville 0250
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hosp.		Length of stay in 1b 4 Days	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last VERA KOUISE PRESCOTT			4. DATE OF DEATH Month Day Year June 4 1958	
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5 1927	9. AGE (In years last birthday) 30	10. FUNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Van Buren, Arkansas	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Ed Snead	13b. MOTHER'S MAIDEN NAME Ethel Dobbins	14. NAME OF HUSBAND OR WIFE Delmer J. Prescott
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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. No	17. INFORMANT Delmer Prescott Address Waynesville, 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) Brain tumor- not operated.		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral Edema	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	

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 a.m. Month, Day, Year 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
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21. I attended the deceased from 6-1-58 to 6-2-58 and last saw her/him alive on 6-2-58 Death occurred at 8:45 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>John P. K. [Signature]</i> (Deceased or title)	22b. ADDRESS 1636 So. Glenstone, Springfield	22c. DATE SIGNED 6-4-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6/4/58	23c. NAME OF CEMETERY OR CREMATORY [Signature]	23d. LOCATION (City, town, or county) (State) Ft. Smith, Arkansas
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24. FUNERAL DIRECTOR Fentress Mortuary ADDRESS Ft. Smith, Ark.	25. DATE RECD. BY LOCAL REG. 6-9-58	26. REGISTRAR'S SIGNATURE <i>Offie G. Melton</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ^{not} ~~was~~ embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

cmf

Signed *H. Mc Cann*

Licensed Embalmer No. *2727*

P. O. Address *Springdale*

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.