

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-021634  
STATE FILE NUMBER

FILED JUN 23 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 623

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Springfield</b> <sup>6396</sup> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Johns Hosp.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>321 E. Lindberg</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First <b>GERALD</b>	Middle <b>SUMNER</b>	Last <b>TALBOT</b>	Month <b>June</b>	Day <b>14,</b>	Year <b>1958</b>

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 August 1925</b>	9. AGE (In years last birthday) <b>32</b>	10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tent and Awning Company</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Kansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>William E. Talbot</b>	13b. MOTHER'S MAIDEN NAME <b>Blanche Halfield</b>	14. NAME OF HUSBAND OR WIFE <b>Wilda Faye Talbot</b>
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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) <b>Yes WWII</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Hospital Records</b> Address
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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) <b>Bacterial septicemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>72 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>(Organism Not yet identified)</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) <b>Basilar skull fracture with hemorrhagic encephalomalacia</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Automobile accident - two car - Hwy M</b>
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20c. TIME OF INJURY Hour Month Day, Year a.m. <b>5-15-58</b> p.m.	<b>near Spfld, Mo. - 5-15-58</b>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Highway M</b>	20f. CITY, TOWN, OR LOCATION <b>Springfield</b> <sup>039</sup> COUNTY <b>Greene</b> STATE <b>Mo.</b>
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21. I attended the deceased from <b>5-15-58</b> to <b>6/14/58</b> and last saw <input checked="" type="checkbox"/> him alive on <b>6/14/58</b> Death occurred at <b>6:25</b> P m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <b>William W. Wood M.D.</b>	22b. ADDRESS <b>Springfield, Missouri</b>	22c. DATE SIGNED <b>6/15/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6-18-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Missouri</b>
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24. FUNERAL DIRECTOR <b>J.W. Klingner &amp; Co.</b>	ADDRESS <b>Spfld. Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>6-16-58</b>	26. REGISTRAR'S SIGNATURE <b>Effie B. Melton</b>
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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. No symptoms will be listed.

JUN 3 1958

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 *Ogden Stone Jr* .....

Licensed Embalmer No. *1176*  
P. O. Address *Springfield* .....

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.