

Health,
& Welfare
Public
Service

76
5. 900
1-57

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-025164
STATE FILE NUMBER

46011-57
FILED AUG 11 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 741A

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN SPRINGFIELD	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHNS HOSPITAL		d. STREET ADDRESS (If outside, give location) 737 MT VERNON	

3. NAME OF DECEASED (Type or print) First Middle Last BARBARA ANN FONVILLE			4. DATE OF DEATH Month Day Year JULY 24 1958		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 24 1958		9. AGE (In years last birthday) 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) SPRINGFIELD, MISSOURI		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME FRANK J FONVILLE		13b. MOTHER'S MAIDEN NAME HELEN LOUISE HESS		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Frank Fonville 737 Mt Vernon Springfield Mo	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Congenital Anomalies (Cardiac & Pulmonary)			INTERVAL BETWEEN ONSET AND DEATH 45 mins.
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 checked="" type="checkbox"/> NO <input 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 **July 24, 1958** to **July 24, 1958** and last saw ^{her} _{him} alive on **July 24, 1958**
Death occurred at **5:25** a **a** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Don S. Overend M.D.		22b. ADDRESS 1211 S. Gloustone, Springfield Mo		22c. DATE SIGNED 8-1-58	
--	--	--	--	-----------------------------------	--

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JULY-26-1958		23c. NAME OF CEMETERY OR CREMATORY EASTLAWN CEMETERY		23d. LOCATION (City, town, or county) (State) SPRINGFIELD, MISSOURI	
--	--	----------------------------------	--	--	--	---	--

24. FUNERAL DIRECTOR Kelley-Ferreil-CONNER		ADDRESS FORDLAND, MO		25. DATE RECD. BY LOCAL REG. 8-4-58		26. REGISTRAR'S SIGNATURE Effie S. Melton	
--	--	--------------------------------	--	---	--	---	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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 *Wm K Ferrell*

Licensed Embalmer No. *4910*

P. O. Address *Rogersville, TN*

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.