

Health,  
& Welfare  
S. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-028795  
STATE FILE NUMBER

FILED AUG 25 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 817

S. 300  
V. 1-57

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Arkansas</b> , b. COUNTY <b>Baxter</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>Mountain Home</b> <sup>8030</sup> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Baptist Hosp.</b>		Length of stay in lb <b>1 day</b>	d. STREET ADDRESS (If outside, give location) <b>607 Baker Street</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle Last <b>Dooley</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>20,</b> Year <b>1958</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1909</b>	9. AGE (In years, last birthday) <b>49</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) <b>Hswife &amp; Merchant</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home &amp; Store</b>	11. BIRTHPLACE (City and state or country) <b>South Fork, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>E. C. Black</b>	13b. MOTHER'S MAIDEN NAME <b>Dora McWhirter</b>	14. NAME OF HUSBAND OR WIFE <b>Athel Dooley</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Athel Dooley, Mt. Home, Arkansas</b>
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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>Cerebral Embolism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>16 hrs</b> <b>2 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Mitral Stenosis &amp; Mural Thrombus</b>	
	DUE TO (c) <b>Rheumatic Heart Disease</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>410X</b>		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.)
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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
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21. I attended the deceased from <b>Dec 27, 1956</b> to <b>Aug 20, 58</b> and last saw her <b>alive on Aug 20, 58</b> Death occurred at <b>2:00 p.</b> 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>A. D. Callaway, Jr. MD</b>	22b. ADDRESS <b>Springfield, Mo</b>	22c. DATE SIGNED <b>Aug 23, 58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-24-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>West Plains, Missouri</b>
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24. FUNERAL DIRECTOR <b>Roller Fun'l. Home, Mt. Home, Ark.</b>	25. DATE RECD. BY LOCAL REG. <b>8-22-58</b>	26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
All diseases in Part I must be causally related.

SEP 10 1951

SEP 8 1951

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  -----

Licensed Embalmer No. 3312  
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.