

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036035
STATE FILE NUMBER

FILED OCT 27 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1004

S. 300
1-57

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	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2036 N. Lyon		d. STREET ADDRESS (If outside, give location) 2036 N. Lyon	
Length of stay in lb 10 years		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last DAISY MAUDE CHITTIM			4. DATE OF DEATH Month Day Year October 19 1958		
---	--	--	--	--	--

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 Sept. 14, 1880		9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months Days Hours Min. 1 5		IF UNDER 24 HRS.	
-------------------------	--	----------------------------------	--	---	--	---	--	--	--	---	--	------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) Cave Springs, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
---	--	--	--	--	--	---	--	--	--	--	--

13a. FATHER'S NAME John Bell Appleby			13b. MOTHER'S MAIDEN NAME Dora Thompson			14. NAME OF HUSBAND OR WIFE Alfred Chittim					
--	--	--	---	--	--	--	--	--	--	--	--

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. None		17. INFORMANT Address Springfield, Mo Ralph Chittim, 1500 E. Portland,							
---	--	--	--	---	--	--	--	--	--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction										INTERVAL BETWEEN ONSET AND DEATH 15 min	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease										5 yrs	
DUE TO (c) 4200											
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 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 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 **11-22-49**, to **10-19-58** and last saw her alive on **7-30-58**.
Death occurred at **6:30 A.M.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Paul C. Morton M.D.			22b. ADDRESS 1631 N Jefferson Springfield, Mo.			22c. DATE SIGNED 10-21-58		
--	--	--	--	--	--	-------------------------------------	--	--

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct 21, 1958		23c. NAME OF CEMETERY OR CREMATORY Cave Springs Cem.		23d. LOCATION (City, town, or county) (State) 5 mi N W Willard, Mo.					
--	--	----------------------------------	--	--	--	---	--	--	--	--	--

24. FUNERAL DIRECTOR ADDRESS Greenwade-Windle, Willard, Mo.			25. DATE RECD. BY LOCAL REG. 10-22-58			26. REGISTRAR'S SIGNATURE Effie E. Melton					
---	--	--	---	--	--	---	--	--	--	--	--

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

No symptoms will be listed.

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 *Robert E. Muhleman*

Licensed Embalmer No. *4916*

P. O. Address *Springfield, Ill.*

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.