

t. Health,
, & Welfare
S. Public
th Service

S. 300
v. 1-57

All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036071
STATE FILE NUMBER

CECIL R. AUNER, M.D.

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1032

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Webster</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Strafford</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Hosp.</u>		Length of stay in lb <u>2 1/2 days</u>	112 ^d STREET ADDRESS <u>Route 1</u> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Daly</u> Last <u>McInturf</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>26</u> Year <u>1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 29, 1889</u>
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tax consultant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Int. Rev.</u>	11. BIRTHPLACE (City and state or country) <u>Magazine, Arkansas</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>William Daly McInturf</u>	
13b. MOTHER'S MAIDEN NAME <u>Laura Keith</u>		14. NAME OF HUSBAND OR WIFE <u>Grace Mabry McInturf</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, [Specify unknown] (If [Specify] or [Specify] of service) <u>Yes World War I</u>		16. SOCIAL SECURITY NO. <u>498-42-9477</u>	
17. INFORMANT <u>Grace McInturf</u>		Address <u>Strafford, Missouri</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of myocardium</u>			INTERVAL BETWEEN ONSET AND DEATH <u>0</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Infarction of myocardium</u>			<u>4 days</u>
DUE TO (c) <u>Coronary thrombosis</u>			<u>4201</u>
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 <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> a.m. <u> </u> p.m. <u> </u>			
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 <u>Oct. 23-'58</u> to <u>Oct. 26-'58</u> and last saw ^{her} him alive on <u>Oct. 25-'58</u> Death occurred at <u>7:40 a.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Cecil R. Auner M.D.</u> (Degree or title)		22b. ADDRESS <u>Springfield, Mo.</u> <u>404 Professional Bldg.</u>	
		22c. DATE SIGNED <u>Oct. 27-'58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-29-1958</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>	
24. FUNERAL DIRECTOR <u>Rex Rainey</u> ADDRESS <u>Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-31-58</u>	
		26. REGISTRAR'S SIGNATURE <u>Offie E. Melton</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

NOV 5 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 *[Handwritten Signature]*

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.