

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036097

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 986A

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>		c. CITY OR TOWN <b>Springfield</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Baptist Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>527 S. Park</b>	

3. NAME OF DECEASED (Type or print) <b>ALBERT ROSE</b>			4. DATE OF DEATH Month <b>October</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>1/1/1878</b>	9. AGE (In years at birthday) <b>80</b>	10. F UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
-----------------------	----------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------	--------------------------------------------	-----------------------------------------------	------------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Railroader</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (City and state or country) <b>Greene County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
--------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------

13a. FATHER'S NAME <b>Townley Rose</b>	13b. MOTHER'S MAIDEN NAME <b>Eglehtine Smyth</b>	14. NAME OF HUSBAND OR WIFE <b>Lela Rose</b>
-------------------------------------------	-----------------------------------------------------	-------------------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Lee Waddle: 2115 W. Elm, Springfield, Mo.</b>
------------------------------------------------------------------------------------------------------------------------	-------------------------------------------	-------------------------------------------------------------------

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>Acute coronary occlusion with myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) <b>Arteriosclerosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4501</b>		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 _____ 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 <b>Springfield</b>	COUNTY <b>Greene</b>	STATE <b>Missouri</b>
---------------------------------------------------	---------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	----------------------------------------------------	-------------------------	--------------------------

21. I attended the deceased from <b>Oct 11, '58</b> to <b>Oct 16, '58</b> and last saw him alive on <b>Oct 16, 1958</b> Death occurred at <b>4:30 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

22a. SIGNATURE <b>Don Silsby M.D.</b>	22b. ADDRESS <b>Springfield, Missouri</b>	22c. DATE SIGNED <b>10/17/58</b>
---------------------------------------	----------------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/16/1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Maple Park</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Missouri</b>
------------------------------------------------------------	--------------------------------	---------------------------------------------------------	-------------------------------------------------------------------------------

24. FUNERAL DIRECTOR <b>AYRE-GOODWIN: Springfield, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>10-22-58</b>	26. REGISTRAR'S SIGNATURE <b>Offic. E. Melton</b>
---------------------------------------------------------------	-------------------------------------------------	------------------------------------------------------

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

NOV 8 1958

DEC 9 1958

NOV 18 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 *Harry [Signature]* .....

Licensed Embalmer No. 4594 .....

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.