

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043783
STATE FILE NUMBER

FILED DEC 22 1958 Registration District No. 128 Primary Registration District No. 2002 Registrar's No. 1204

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 Stone	
b. CITY (If outside corporate limits, give TOWNSHIP only) Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Blue Eye
c. FULL NAME OF (If NOT in hospital, give location) Baptist Hospital		Length of stay in lb Few days	d. STREET ADDRESS (If outside, give location) Blue Eye
3. NAME OF DECEASED (Type or print) First Middle Last PEARLIE A. HERRING			4. DATE OF DEATH Month Day Year December 11, 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 Dec. 31, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 57
13a. FATHER'S NAME F. B. Baker		13b. MOTHER'S MAIDEN NAME Agnes Simpson	14. NAME OF HUSBAND OR WIFE F. S. Herring
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. Unknown	17. INFORMANT Address F. S. Herring, Blue Eye, Missouri
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertensive Cardiovascular Disease			39 Days
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 443X	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <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 Nov. 2, 1958 to Dec. 11, 1958 and last saw her alive on _____ Death occurred at 6:25 am m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or Title) Stanley S. Peterson M.D.		22b. ADDRESS Springfield, Missouri	22c. DATE SIGNED 17 Dec 58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Dec. 11, '58	23c. NAME OF CEMETERY OR CREMATORY Blue Eye Cemetery	23d. LOCATION (City, town, or county) (State) Blue Eye, Missouri
24. FUNERAL DIRECTOR ADDRESS AYRE-GOODWIN: Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 12-17-58	26. REGISTRAR'S SIGNATURE Offie S. Melton

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

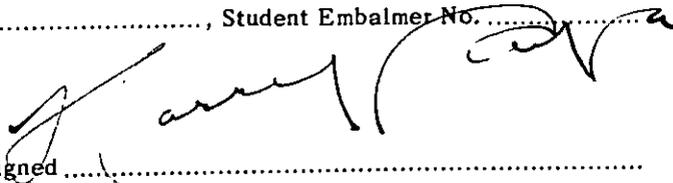
MEDICAL CERTIFICATION

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 

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.