

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000911

STATE FILE NUMBER

FILED JAN 12 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 14

300
1-57

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>Dallas</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>Buffalo</u> 0300		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>			Length of stay in 1b <u>6 Days</u>	d. STREET ADDRESS (If outside, give location) <u>on Locust St.</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>E.</u> Last <u>ALEXANDER</u>				4. DATE OF DEATH Month <u>1-</u> Day <u>3-</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>red</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-25-1872</u>		9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>9</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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	11. BIRTHPLACE (City and state or country) <u>Dallas, Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>John Welch</u>		13b. MOTHER'S MAIDEN NAME <u>Magdellene Vanderbilt</u>		14. NAME OF HUSBAND OR WIFE <u>Frank Alexander (Deceased)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Ruth Alexander Buffalo Mo.</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>BRONCHO PNEUMONIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Fractured Hip</u>						<u>6 days</u>	
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized Arteriosclerosis</u>						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 <u>030</u>		COUNTY _____ STATE _____		
21. I attended the deceased from <u>12-28-58</u> to <u>1-3-59</u> and last saw her alive on <u>1-3-59</u> Death occurred at <u>4:15 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Harold H. Lurie, M.D.</u>			22b. ADDRESS <u>609 Cherry Springfield, Mo.</u>		22c. DATE SIGNED <u>1-6-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-4-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		23d. LOCATION (City, town, or country) (State) <u>Buffalo Mo.</u>			
24. FUNERAL DIRECTOR <u>L.B. Jones</u>			ADDRESS <u>Buffalo, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-8-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie Z. Melton</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

APR 24 1920

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 me, Student Embalmer No. 4 working under my personal supervision.

Student ✓
Signature of Student Embalmer

Signed R. E. Cleatham

Licensed Embalmer No. 3813

P. O. Address Buffalo, 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.