

Dr. J. Williams

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000931  
STATE FILE NUMBER

FILED JAN 12 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 23

All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

John W. Williams, Jr., M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

- 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>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>SPRINGFIELD</b> c 3, 6 0
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOHN'S HOSP.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>2428 N. FREMONT</b>
3. NAME OF DECEASED (Type or print) First <b>EUGENE</b> Middle Last <b>CLINGAN</b>			4. DATE OF DEATH Month <b>JAN.</b> Day <b>6</b> Year <b>1959</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>SEPT. 6 1885</b>
9. AGE (In years last birthday) <b>73</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PIPEFITTER</b>	11. BIRTHPLACE (City and state or country) <b>BUCYRUS, OHIO</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>A.W. CLINGAN</b>	13b. MOTHER'S MAIDEN NAME <b>SUE LANKFORD</b>
14. NAME OF HUSBAND OR WIFE <b>GRACE CLINGAN</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>490-10-0446</b>
17. INFORMANT <b>MRS. GRACE CLINGAN</b>		Address <b>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) <u><i>Fractured Aortic Aneurysm</i></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u><i>Deteria - sepsis - general.</i></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) _____			INTERVAL BETWEEN ONSET AND DEATH <u><i>5 hrs</i></u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		451X 1	
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.) <b>ITEM 22c CORRECTED</b>		
20c. TIME OF INJURY Hour _____ 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 <b>SPRINGFIELD MISSOURI</b>	
21. I attended the deceased from <u><i>Dec 29, 1958</i></u> to <u><i>Jan 6, 1959</i></u> and last saw him/her alive on <u><i>Jan 6, 1959</i></u> Death occurred at <u><i>7 A.M.</i></u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>John W. Williams, Jr.</i>		22b. ADDRESS <i>Springfield Mo</i>	22c. DATE SIGNED <i>1-6-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>1/9/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PARK CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>CARTHAGE, MISSOURI</b>
24. FUNERAL DIRECTOR <b>H.H. LOHMEYER</b>		ADDRESS <b>SPRINGFIELD, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>1-2-59</b>
26. REGISTRAR'S SIGNATURE <i>E. J. Meltzer</i>			

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 ..... *Gene C. Hunter* .....

Licensed Embalmer No. *4739* .....

P. O. Address *Spokane* .....

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.