

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000998

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 109

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield ⁰³⁹⁶ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 519 Cherry		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1450 N. Broadway Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last IRENE MORRIS			4. DATE OF DEATH Month Day Year January 30, 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 Feb. 1880
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) INDIANA
12. CITIZEN OF WHAT COUNTRY? USA		13. NAME OF HUSBAND OR WIFE DECEASED	
13a. FATHER'S NAME JAMES TEAFORD		13b. MOTHER'S MAIDEN NAME MARTHA LOMAX	
14. NAME OF DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT PAULINE DEMOSS Address ST. LOUIS, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) arteriosclerosis, general DUE TO (c) 4200 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Dec 11, 1958 amputation, above knee, right, arteriosclerotic			INTERVAL BETWEEN ONSET AND DEATH 1-2 yrs Chronic
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 Month, Day, Year 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 COUNTY STATE
21. I attended the deceased from Nov 1958 to 1/30/59 and last saw her alive on Jan 26, 1959 Death occurred at 1:45 a m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Don J. Silsby M.D.		22b. ADDRESS McDaniel Building Springfield, Missouri	
22c. DATE SIGNED 1-30-59		23. NAME OF CEMETERY OR CREMATORY GREENLAWN	
23a. LOCATION (City, town, or county) (State) SPRINGFIELD, Mo.		23b. DATE 2-2-59	
23c. NAME OF CEMETERY OR CREMATORY GREENLAWN		23d. LOCATION (City, town, or county) (State) SPRINGFIELD, Mo.	
24. FUNERAL DIRECTOR J.W. KLINGNER & CO. SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 2-3-59	
26. REGISTRAR'S SIGNATURE Effie E. Melton		26. REGISTRAR'S SIGNATURE	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health, Welfare, Public Service

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All diseases in Part I must be causally related.

jhc

(Licensed Embalmer's Statement on Reverse Side)

FEB 18 1959

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 *Mal Rhodes*
Licensed Embalmer No. *4071*
P. O. Address *...*

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.