Health, & Welfare Public Service

300 C
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-001018
STATE FILE NUMBER

FILED FEB 2 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 85

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY OR TOWN Springfield — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION Handley Hospital — Length of stay in 1b: Lifetime

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Greene
c. CITY OR TOWN Springfield 6396 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 314 N. Nettleton — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First ARTIE Middle DEE Last ROSE

4. DATE OF DEATH Month January Day 23 Year 1959

5. SEX Male

6. COLOR OR RACE White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]

8. DATE OF BIRTH March 28, 1887

9. AGE (In years last birthday) 71 — 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) Shop worker

10b. KIND OF BUSINESS OR INDUSTRY Frisco Railway

11. BIRTHPLACE (City and state or country) Greene Co., Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Taylor Rose

13b. MOTHER'S MAIDEN NAME Almieda Conn

14. NAME OF HUSBAND OR WIFE ----

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT Address Mrs F. H. Hilton, Springfield, Mo.

MEDICAL CERTIFICATION

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 Apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 334X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 Jan 20, 1959, to Jan 23, 1959 and last saw ~~the~~ him alive on Jan. 22, 1959
Death occurred at 5:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Lyman D. Brown (Degree or title) M.D. — **22b. ADDRESS** 311½ College — **22c. DATE SIGNED** 1/24/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial — **23b. DATE** Jan 26, 1959 — **23c. NAME OF CEMETERY OR CREMATORY** YEAKLEY CEMETERY — **23d. LOCATION** (City, town, or county) Springfield, Mo. (State)

24. FUNERAL DIRECTOR Jewell E. Windle — **ADDRESS** B.W. Springfield, Mo. — **25. DATE RECD. BY LOCAL REG.** 1-28-59 — **26. REGISTRAR'S SIGNATURE** Effie B. Mellon

(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

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 ..... Signed Bernard F. Wright
Signature of Student Embalmer

Licensed Embalmer No. 4293
P. O. Address Springfield

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.