Health, & Welfare Public Service

Dr. Calloway Jr.

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005141

STATE FILE NUMBER

FILED FEB 24 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 163A

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 OR TOWN (If outside corporate limits, give TOWNSHIP only) SPRINGFIELD — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN SPRINGFIELD — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 932 STATE — Length of stay in lb 84 YRS.	d. STREET ADDRESS (If outside, give location) 932 STATE — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print)	First THOMAS	Middle H.	Last GIDEON
4. DATE OF DEATH	Month FEB.	Day 12	Year 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]	
8. DATE OF BIRTH JAN. 12 1875	9. AGE (In years last birthday) 84	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) LAWYER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) SPRINGFIELD, MO.	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME T.J. GIDEON	13b. MOTHER'S MAIDEN NAME WILLIAMS	14. NAME OF HUSBAND OR WIFE DELLA GIDEON (DEC.)	
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. 500-34-0199A	17. INFORMANT J. OLIVER GIDEON	Address 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) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 2 mos

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) Carcinoma of Prostate 420CH

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 10, 1959, to Feb 12, 59 and last saw him alive on Jan 27, 1959

Death occurred at 11 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H D Calloway, J M D	22b. ADDRESS Springfield, Mo	22c. DATE SIGNED Feb 16, 59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 2/17/59	23c. NAME OF CEMETERY OR CREMATORY HAZELWOOD
23d. LOCATION (City, town, or county) SPRINGFIELD, MO. (State)		
24. FUNERAL DIRECTOR H.H. LOHMEYER	ADDRESS SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 2-17-59
26. REGISTRAR'S SIGNATURE Effie G. Melton		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

OCT 30 1964

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. 2727

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.