

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005191

STATE FILE NUMBER

FILED FEB 16 1959

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 142

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 <u>c 346</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital		Length of stay in lb 60 years	d. STREET ADDRESS 823 S. Holland Ave. (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First SARAH Middle FLORENCE Last NIX			4. DATE OF DEATH Month Feb. Day 8, Year 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 Sept. 1884	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during part of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William DeWitt		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE John Nix	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. ----		17. INFORMANT Mrs. J.C. Mahoney, Springfield, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage					INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
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) 331x					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. Month, Day, Year _____					
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 <u>12-2-44</u> to <u>2-8-59</u> and last saw her alive on <u>2-8-59</u> Death occurred at <u>6:30 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) J.P. Mahoney M.D.			22b. ADDRESS Springfield, Mo		22c. DATE SIGNED 2/9/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-11-59	23c. NAME OF CEMETERY OR CREMATORY East Lawn		23d. LOCATION (City, town, or county) (State) Springfield, Missouri
24. FUNERAL DIRECTOR Ralph Thieme, Springfield, Missouri			25. DATE RECD. BY LOCAL REG. 2-10-59	26. REGISTRAR'S SIGNATURE Effie G. Melton	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 *Lee Mason*

Licensed Embalmer No. *42568*

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.