

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005200

STATE FILE NUMBER

FILED FEB 16 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 898

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dade</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Greenfield</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 <u>650 S. Nettleton</u>		Length of stay in lb <u>2 months</u>		d. STREET ADDRESS (If outside, give location) <u>101 Grand Ave</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Thomas Preston</u>				4. DATE OF DEATH Month Day Year <u>Jan. 24, 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 26, 1873</u>		9. AGE (In years last birthday) <u>85</u>	10. UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state or country) <u>Caplinger Mills, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Moses Laffayette Preston</u>		13b. MOTHER'S MAIDEN NAME <u>Caroline Matilda Oaks</u>		14. NAME OF HUSBAND OR WIFE <u>Nannie Margaret Preston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Wallace L. Preston; Springfield, Mo.</u>			
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>Bronchopneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Malnutrition</u>						Not Known	
DUE TO (c) <u>Cerebral Thrombosis</u>						15 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>332X</u>						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 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		COUNTY	STATE
21. I attended the deceased from <u>12-10-58</u> to <u>1-24-59</u> and last saw ^{him} alive on <u>9 am 1-24-59</u> Death occurred at <u>12:25</u> p. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Albert P. Simpson, M.D.</u> (Degree or title)				22b. ADDRESS <u>301 Springfield Med Bldg Springfield, Mo.</u>		22c. DATE SIGNED <u>2-5-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan. 26, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wright Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Cedar County, Mo.</u>		
24. FUNERAL DIRECTOR <u>J. C. Canada, Greenfield, Mo.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>2-9-59</u>		26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *J. C. Canada*

Licensed Embalmer No. *4196*
P. O. Address *Greenfield, Wis.*

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.