

Health,
Welfare
Public
Service

DR. W.B. JOHNSON

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009053

STATE FILE NUMBER

FILED APR 6 1959

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 345

300

1-57

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY CEDAR				
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 STOCKTON			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BURGE HOSP.		Length of stay in 1b 8 HRS.	d. STREET ADDRESS ROUTE # 3			
3. NAME OF DECEASED (Type or print) First LUCY Middle MAUDEN Last FOX			4. DATE OF DEATH Month MARCH Day 30 Year 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 28 1912	9. AGE (In years last birthday) 46	F 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	11. BIRTHPLACE (City and state or country) GREENFIELD, MO.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME RICE TODD		13b. MOTHER'S MAIDEN NAME EDITH DEPER		14. NAME OF HUSBAND OR WIFE LELAND FOX		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	17. INFORMANT Address LELAND FOX STOCKTON, 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) Cerebral hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) Hypertensive cardiovascular disease DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 12 hr. unknown	
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.						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 Springfield, Mo		COUNTY Springfield	
21. I attended the deceased from Death occurred at 2:50 A.M.			and last saw her him alive on _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W. B. Johnson		(Degree or title)	22b. ADDRESS Springfield, Mo		22c. DATE SIGNED 3-30-59	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 4/1/59	23c. NAME OF CEMETERY OR CREMATORY STOCKTON CITY CEM.		23d. LOCATION (City, town, or county) STOCKTON, MO.		
24. FUNERAL DIRECTOR H.H. LOHMEYER			ADDRESS SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 4-1-59	26. REGISTRAR'S SIGNATURE Effie S. Melton	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

Licensed Embalmer No.....

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.