

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009065
STATE FILE NUMBER

FILED APR 14 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 351

300
1-57

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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, ⁰³⁹⁶ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 519 Cherry		d. STREET ADDRESS (If outside, give location) 685 S. Hollison Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Magdaline Last Hutton		4. DATE OF DEATH April 1, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 7, 1866
9. AGE (In years last birthday) 93		IF UNDER 1 YEAR Months 1 Days 24	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 In Home	11. BIRTHPLACE (City and state or country) Spickard, Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME George A. Spickard	
13b. MOTHER'S MAIDEN NAME Mary Ann Thompson		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or <u>no</u>) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Miss Esther Hutton Springfield, 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) Broncho pneumonia			INTERVAL BETWEEN ONSET AND DEATH 6 hours
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) Fractured left femur 2-10-59			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 2-2-58 to 4-1-59 and last saw her alive on 4-1-59 6³⁰ pm Death occurred at 10 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Albert P. Simpson, M.D.		22b. ADDRESS 301 Springfield Med Bldg. Springfield, Mo.	
22c. DATE SIGNED 4-9-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 4, 1959	
23c. NAME OF CEMETERY OR CREMATORY Maple Park		23d. LOCATION (City, town, or county) (State) Springfield, Missouri	
24. FUNERAL DIRECTOR ADDRESS Gorman-Scharpf Funeral Home Springfield, Missouri		25. DATE RECD. BY LOCAL REG. 4-10-59	
26. REGISTRAR'S SIGNATURE Effie E. Melton			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Director, coroner, etc.: first use only standard nomenclature in item 18. No symptoms with the patient. 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 *Lewis G. Scheraga*

Licensed Embalmer No. *3802*

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.