

Dr. Wakeman

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-009094  
STATE LICENSE NUMBER

FILED APR 14 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 367

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>SPRINGFIELD</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOHN'S HOSP.</b>		Length of stay in 1b <b>30 YRS.</b>	d. STREET ADDRESS (If outside, give location) <b>611 E. NORMAL</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>LORETTA</b> Last <b>REED</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>7</b> Year <b>1959</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 14 1898</b>		9. AGE (In years last birthday) <b>60</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>FT. SMITH, ARK.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>WILLIAM HENRY</b>		13b. MOTHER'S MAIDEN NAME <b>BRIDGET DUFF</b>	
14. NAME OF HUSBAND OR WIFE <b>LOWELL B. REED</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>LOWELL B. REED</b>		Address <b>SPRINGFIELD, MO.</b>		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>Hemorrhage from Ruptured Esophageal Varices</u> DUE TO (b) <u>Cirrhosis of Liver &amp; Ascites</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____	
19. INTERVAL BETWEEN ONSET AND DEATH <b>581C</b>		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.		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 <b>Springfield Mo</b>		COUNTY _____ STATE _____	
21. I attended the deceased from <u>Mar 21, 59</u> to <u>Apr 7, 59</u> and last saw her alive on <u>Apr 7, 1959</u> Death occurred at <u>2:05 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>J. Newton Wakeman MD</u> (Degree or title)		22b. ADDRESS <u>Springfield Mo</u>	
22c. DATE SIGNED <u>4-8-59</u>		23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>4/17/59</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT. CALVARY</b>		23d. LOCATION (City, town, or county) <b>MONETT, MISSOURI</b>		(State)	
24. FUNERAL DIRECTOR <b>H.H. LOHMEYER</b>		ADDRESS <b>SPRINGFIELD, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>4-9-59</b>	
26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>		(Licensed Embalmer's Statement on Reverse Side)			

Use only black ink or ribbon typewrite if possible. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 *H. L. McCann* .....

Licensed Embalmer No. *2727* .....

P. O. Address *Springfield, Mo.* .....

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.