

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012093  
STATE FILE NUMBER

REG. MAR 24 1959 Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 49

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Springfield</u> 0396 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #3</u> Length of stay in lb <u>29 10 54</u>		d. STREET ADDRESS (If outside, give location) <u>Unknown</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EARL</u> Middle Last <u>KREIDER</u>		4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-8-1889</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) <u>70</u> IF 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) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	10c. BIRTHPLACE (City and state or country) <u>Springfield, Mo</u>
10d. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. BIRTHPLACE (City and state or country)	
13a. FATHER'S NAME <u>Thomas B. Kreider</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth B. Fulk</u>	
14. NAME OF HUSBAND OR WIFE <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hospital records</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>Osteosarcoma of left hip</u> <u>operated on the 11<sup>th</sup> of March 1959</u> 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) <u>Dementia Praecox - Paranoid Type. 1967</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2		20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> None <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>12/31/1956</u> to <u>3/14/1959</u> and last saw <u>him</u> alive on <u>3/14/1959</u> Death occurred at <u>2:45 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>George Ecker, M.D.</u> (Degree or title)		22b. ADDRESS <u>State Hosp. No. 3 Nevada, Mo</u>	
22c. DATE SIGNED <u>3/14/1959</u>		23a. BURIAL, CREMATION, REINBURSEMENT (Specify) <u>Burial</u>	
23b. DATE <u>3/16/1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Local</u>	
23d. LOCATION (City, town, or county) <u>Springfield, Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>Rainey Funeral Home - Springfield, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>3-18-1959</u>	
26. REGISTRAR'S SIGNATURE <u>Armas &amp; Ferris</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

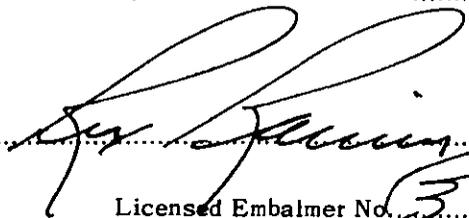
MEDICAL CERTIFICATION

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.

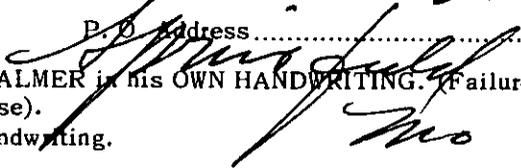
STATEMENT BY LICENSED EMBALMER

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. 331

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.