

Dr. Glenn

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012950

STATE FILE NUMBER

FILED MAY 11 1959

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 454

S. 300
1-57

1. PLACE OF DEATH a. COUNTY GREENE			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. MISSOURI b. COUNTY LAWRENCE				
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 AURORA		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) W. HANDLEY ST.		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last EDDIE ELLIS HENDRIX			4. DATE OF DEATH Month Day Year MAY 4 1959				
5. SEX MALE	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 MARCH 15 1904		9. AGE (In years last birthday) 55		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE		11. BIRTHPLACE (City and state or country) MARIONVILLE, MO. 6			
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME ELLIS NIECE HENDRIX		13b. MOTHER'S MAIDEN NAME LILLIAN JEFFERIES			
14. NAME OF HUSBAND OR WIFE CLARA HENDRIX		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. 486-03-6182			
17. INFORMANT CLARA HENDRIX		Address AURORA, 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) Acute Myocardial Infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Chronic Atherosclerotic Heart Disease. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4260		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 years 3 1/2 years	
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 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 11-2257 , to 5-4-59 and last saw him alive on 5-4-59 Death occurred at 1:40 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE E. E. Glenn (Name and title)		22b. ADDRESS M.D. 609 Cherry-Springfield, Mo.		22c. DATE SIGNED 5-5-59			
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		23b. DATE 5/7/59		23c. NAME OF CEMETERY OR CREMATORY IOOF CEMETERY			
23d. LOCATION (City, town, or county) (State) MARIONVILLE, MO.		24. FUNERAL DIRECTOR H.H. LOHMEYER		25. DATE RECD. BY LOCAL REG. 5-6-59			
26. REGISTRAR'S SIGNATURE Effie E. Melton							

(Licensed Embalmer's Statement on Reverse Side)

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.