

Dr. Purcell

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012959

STATE FILE NUMBER

FILED MAY 4 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 417B

S. 300
1-57

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

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
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION MERCY HOSP.		Length of stay in lb 40 YRS.	d. STREET ADDRESS (If outside, give location) 1011 E. HARRISON
3. NAME OF DECEASED (Type or print) First Middle Last LAURA M. KILBURN			4. DATE OF DEATH Month Day Year APRIL 22 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 MARCH 29 1873
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) RICHMOND, INDIANA
13a. FATHER'S NAME IRA STANLEY		13b. MOTHER'S MAIDEN NAME HANNAH LESTER	14. NAME OF HUSBAND OR WIFE COLLINS KILBURN
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 COLLINS KILBURN 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) Diabetes mellitus Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 260x			INTERVAL BETWEEN ONSET AND DEATH 2 years
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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. Month, Day, Year p.m.			
20d. INJURY OCCURRED WHILE AT <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 8-16-51 , to 4-22-59 and last saw her alive on 4-22-59 Death occurred at 12:20 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Elmer M. Purcell		22b. ADDRESS M.D. 609 Cherry-Springfield, Mo.	22c. DATE SIGNED 4-23-59
23a. BURIAL, CREMATION, REBURY (Specify)	23b. DATE 4/25/59	23c. NAME OF CEMETERY OR CREMATORY NEWCOMER'S CREMATORY	23d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI
24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 4-27-59	26. REGISTRAR'S SIGNATURE Effie E. Melton

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 *Gene C. Smith*
Licensed Embalmer No. *4739*
P. O. Address *St. Louis*

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.