

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012971

STATE FILE NUMBER

FILED APR 20 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 386

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| 1. PLACE OF DEATH a. COUNTY GREENE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE MISSOURI b. COUNTY GREENE | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD | | c. CITY OR TOWN SPRINGFIELD | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP. | | Length of stay in lb 50 YRS. | |
| d. STREET ADDRESS 500 E. WALNUT | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MABEL Middle LOHMEYER Last LOHMEYER | | 4. DATE OF DEATH Month APRIL Day 11 Year 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 APRIL 4 1894 |
| 9. AGE (In years last birthday) 65 | | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 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) MONETT, MISSOURI |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13a. FATHER'S NAME MICHAEL KETCHUM | |
| 13b. MOTHER'S MAIDEN NAME MARY ANN RANDALL | | 14. NAME OF HUSBAND OR WIFE HERMAN H. LOHMEYER | |
| 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. 500-40-965 | 17. INFORMANT Address HERMAN H. LOHMEYER 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) CEREBRAL HEMORRHAGE | | | INTERVAL BETWEEN ONSET AND DEATH 27 HRS. |
| DUE TO (b) GENERALIZED ARTERIOSCLEROSIS | | | |
| DUE TO (c) HYPERTENSIVE CARDIOVASCULAR DIS. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | 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 <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> | | | |
| 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 <u>4/25/59</u> to <u>4/11/59</u> and last saw her alive on <u>4/11/59</u> Death occurred at <u>I; 20 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <i>Harold H. Lurie, M.D.</i> (Degree or title) | | 22b. ADDRESS 609 CHERRY SPRINGFIELD, MO. | 22c. DATE SIGNED 4/13/59 |
| 23a. BURIAL, CREMATION, REINTERMENT (Specify) BURIAL | 23b. DATE 4/14/59 | 23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY | 23d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO. |
| 24. FUNERAL DIRECTOR H.H. LOHMEYER ADDRESS SPRINGFIELD, MO. | | 25. DATE RECD. BY LOCAL REG. 4-17-59 | 26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

never, common, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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. Hunter*

Licensed Embalmer No. *4739*

P. O. Address *Spfld, 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.