

Dr. Johnston

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013009

STATE FILE NUMBER

FILED APR 20 1959

Registration District No.

128

Primary Registration District No.

2000

Registrar's No.

361 A

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>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOHN'S HOSP.</b>		Length of stay in 1b	d. STREET (If outside, give location) ADDRESS <b>1920 S. DELAWARE</b>
3. NAME OF DECEASED (Type or print) First Middle Last <b>INFANT DAUGHTER OF MR. MRS. PATRICK SULLIVAN</b>		4. DATE OF DEATH Month Day Year <b>APRIL 4 1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 4 1959</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>SPRINGFIELD, MO.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>PATRICK SULLIVAN</b>	
13b. MOTHER'S MAIDEN NAME <b>ALMA JEAN EIDSON</b>		14. NAME OF HUSBAND OR WIFE <b>X</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT Address <b>PATRICK SULLIVAN 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) <b>Asphyxia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Intrauterine Infection</b>			<b>24 hrs</b>
DUE TO (c) <b>Premature Rupture Membrane</b>			<b>48 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>7610</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 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 <b>Apr 4-59</b> to <b>April 4-59</b> and last saw her alive on <b>April 4-1959</b> Death occurred at <b>12 NOON</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>J. L. Johnston MD</b> (Degree or title)		22b. ADDRESS <b>Springfield, Mo</b>	22c. DATE SIGNED <b>4-10-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>4/6/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD, MO.</b>
24. FUNERAL DIRECTOR <b>H. H. LOHMEYER</b> ADDRESS <b>SPRINGFIELD, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>4-15-59</b>	26. REGISTRAR'S SIGNATURE <b>Effie E. Melton</b>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Mot Embalmer* .....

Licensed Embalmer No.....

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.