

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013021

STATE FILE NUMBER

FILED APR 20 1959

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 394

300  
1-57

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> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Handley Hospital</b>		Length of stay in 1b <b>26 days</b>	STREET ADDRESS (If outside, give location) <b>811 N. Fulbright</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES WILLIAM VAN DYCK, III</b>			4. DATE OF DEATH Month Day Year <b>April 14, 1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1959</b>
9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <b>26</b> Days <b>26</b> IF UNDER 24 HRS.: Hours <b>26</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (City and state or country) <b>Springfield, Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>James William VanDyck</b>	
13b. MOTHER'S MAIDEN NAME <b>Eva Rogers</b>		14. NAME OF HUSBAND OR WIFE <b>none</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>none</b>	
17. INFORMANT <b>Mrs. Eva VanDyck, Springfield, Mo.</b>		Address	
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>Pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>UNATTENDED BY A PHYSICIAN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>7630</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <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 _____ to <b>4/14/59</b> and last saw him alive on _____ Death occurred on <b>5:00 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>James O. Moore, M.D.</b>		22b. DATE SIGNED <b>4-17-59</b>	
22c. ADDRESS <b>Greene Co. Health Dept., County Health of Springfield - Mo</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-16-59</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Eastlawn</b>		23d. LOCATION (City, town, or county) (State) <b>Springfield, Mo</b>	
24. FUNERAL DIRECTOR <b>Ralph Thieme, Springfield, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>4-17-59</b>	
		26. REGISTRAR'S SIGNATURE <b>Effie S. Mellon</b>	

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 ..... *Lee Mason* .....

Licensed Embalmer No. .... 4568 .....

P. O. Address ..... Springfield, M.....

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.