

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013033

FILED MAY 4 1959

Registration District No. 128 Primary Registration District No. _____ STATE FILE NUMBER _____ Registrar's No. 425A

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 Fair Grove		c. CITY OR TOWN Fair Grove c 390 0	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Fair Grove		d. STREET ADDRESS None (If outside, give location)	
3. NAME OF DECEASED (Type or print) DOROTHY		4. DATE OF DEATH Month Day Year April 25, 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 20 Feb. 1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Missouri
13a. FATHER'S NAME John B. Moore		13b. MOTHER'S MAIDEN NAME Tamsy Hoover	14. NAME OF HUSBAND OR WIFE Troy Adams
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 Troy Adams Fair Grove, 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) Arteriosclerotic valvular heart disease			INTERVAL BETWEEN ONSET AND DEATH Unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 414X			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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 Springfield, Missouri		20g. COUNTY Dallas STATE Missouri	
21. I attended the deceased from Jan '52 to 4/25/59 and last saw her alive on 12-16-58 Death occurred at 3:45 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Wendell B. Shuman</i> (Degree or title)		22b. ADDRESS 609 Cherry Springfield, Missouri	
22c. DATE SIGNED 5-1-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-28-59	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION (City, town, or county) (State) Dallas County, Missouri	
24. FUNERAL DIRECTOR J.W. KLINGNER & CO. SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 5-1-59	
26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i>			

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 *Ogle Stone Jr.*
Licensed Embalmer No. *4176*
P. O. Address *Springfield*

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.