

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017364
STATE FILE NUMBER

FILED MAY 18 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 457B

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Dade			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield Mo		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN So. Greenfield Mo		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Baptist Hospital		Length of stay in lb 2 days		d. STREET OR ADDRESS 0290 Smith TWP		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Graec Isabelle Lieuallen				4. DATE OF DEATH Month Day Year Ma y 5 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 24 1932		9. AGE (In years at birthday) 26 IF UNDER 1 YEAR Months Days 6 11 IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and state or country) So Greenfield Mo		12. CITIZEN OF WHAT COUNTRY? usa	
13a. FATHER'S NAME Hubert Lieuallen			13b. MOTHER'S MAIDEN NAME Hattie Isabelle Preston			14. NAME OF HUSBAND OR WIFE	
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. 496-34-4322 none		17. INFORMANT Address Hubert Lieuallen So. Greenfield Mo rtl			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Cardiac Arrest during anesthesia (general)						30 hours	
DUE TO (c) Chronic Tonsillitis (reason for anesthesia)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 5101						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 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 8 A.M. 5-4-59 , to 7:30 P.M. 5-5-59 and last saw her/him alive on May 5 7:25 P.M. Death occurred at 7:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>William P. ...</i> (Degree or title) 0			22b. ADDRESS 205 St. Louis St. Springfield			22c. DATE SIGNED 5-8-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 8 1959	23c. NAME OF CEMETERY OR CREMATORY Kings Point		23d. LOCATION (City, town, or county) (State) Dade Co Mo.		
24. FUNERAL DIRECTOR W.R. Allison ADDRESS Greenfield Mo.			25. DATE RECD. BY LOCAL REG. 5-11-59		26. REPORTER'S SIGNATURE Effie S. Melton		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *W. R. Allison*

Licensed Embalmer No. *4407*

P. O. Address *Frankfield*

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.