

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017385

STATE FILE NUMBER

LED MAY 18 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 475

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		c. CITY OR TOWN SPRINGFIELD	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION FOSTER REST HOME		STREET ADDRESS (If outside, give location) 2247 LYON	

3. NAME OF DECEASED (Type or print) First Middle Last BERTHA IDA O'NEAL			4. DATE OF DEATH Month Day Year 5-11-59		
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 FEB. 1886	9. AGE (In years last birthday) 73	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS Hours Min.
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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) ILLINOIS	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME W.W. HAHAN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE DECEASED
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT FLOYD HERRING	Address SPGFD. MO.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Renal Vascular Disease N.K.		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)	
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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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 SPRINGFIELD	COUNTY GREENE	STATE MO.
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21. I attended the deceased from 10-15-54 to 5-11-59 and last saw her alive on 4-4-59 Death occurred at 2:45 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.	22a. SIGNATURE <i>[Signature]</i>	22b. ADDRESS 1715 Bronville Springfield Missouri	22c. DATE SIGNED 5-12-59
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23a. BURIAL, CREMATION, or other (Specify) Cremation	23b. DATE 5-14-59	23c. NAME OF CEMETERY OR CREMATORY MAPLE PARK	23d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO.
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24. FUNERAL DIRECTOR W. A. Kugner No 504	ADDRESS No 504	25. DATE REC'D. BY LOCAL REG. 5-13-59	26. REGISTRAR'S SIGNATURE Effie S. Melton
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

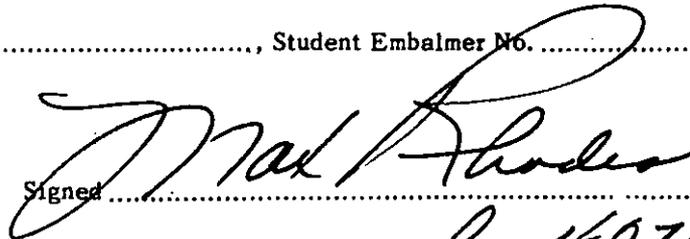
All diseases in Part I must be causally related.

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



Licensed Embalmer No. 407.....

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.