

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017413  
STATE FILE NUMBER

FILED JUN 8 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 521A

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>Howell</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>Willow Springs</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hosp.</b>		Length of stay in 1b <b>30 Minutes</b>	d. STREET ADDRESS (If outside, give location) <b>046</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>VAN KENTON TWIST</b>			4. DATE OF DEATH Month Day Year <b>May 26, 1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1933</b>
9. AGE (In years last birthday) <b>25</b>		IF UNDER 1 YEAR Months Days <b>10 14</b>	IF UNDER 24 HRS. Hours Min. <b>14</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe fitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>	11. BIRTHPLACE (City and state or country) <b>Salina Okla.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>F.A. Twist</b>	13b. MOTHER'S MAIDEN NAME <b>Rosalee Ryan</b>
14. NAME OF HUSBAND OR WIFE <b>Ruby Mick Twist</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <del>no</del> unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>467-42-8310</b>		17. INFORMANT Address <b>Ruby Twist, Willow Springs, Missouri</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>Traumatic shock with massive blood loss secondary to compound fracture of left lower extremities</b> Fracture of left hip and contusions of face 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)			INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) <b>headon crash of two cars a mile east of Norwood on</b>			
20c. TIME OF INJURY Hour Month, Day, Year <b>5 to 7:30 p.m. May 26 1959</b>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Hi way 60</b>	
20e. CITY, TOWN, OR LOCATION <b>Norwood</b>		COUNTY STATE <b>Wright Missouri</b>	
21. I attended the deceased from <b>7:30 P.M.</b> to <b>7:30 P.M.</b> and last saw <del>him</del> <sup>her</sup> alive on <b>May 26, 1959</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>John W. Polk, MD M. D.</b>		22b. ADDRESS <b>604 Medical Arts Bldg Springfield, Missouri</b>	
22c. DATE SIGNED <b>5-28-59</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
23b. DATE <b>27 May 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>San Antonio Crematory</b>	
23d. LOCATION (City, town, or county) (State) <b>San Antonio Texas</b>		24. FUNERAL DIRECTOR <b>Ralph Thieme, Springfield, Missouri</b>	
DATE RECD. BY LOCAL REG. <b>6-4-59</b>		26. REGISTRAR'S SIGNATURE <b>Effie E. Melton</b>	

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

John W. Polk, M.D.

6361 8 NOV

VS  
MAY 19 1980

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 *Ralph H. Steiner*

..... Licensed Embalmer No. *3681*

P. O. Address *Springfield, Mo*

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.