

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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59-024733

Registration District No. 228 Primary Registration District No. 2000 Registrar's No. 818

STATE FILE NUMBER 1

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Greene</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b> Length of stay in 1b <b>45 years</b> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Burge Hospital</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b> c. CITY OR TOWN <b>Springfield</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>1962 Eureka Terrace</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <b>MAY</b> Middle <b>CAROLINE</b> Last <b>BUDLONG</b>			<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>30</b> Year <b>1959</b>		
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<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Mar. 5, 1872</b>	<b>9. AGE (last birthday)</b> <b>87</b>	<b>IF UNDER 1 YEAR</b> Months <b>4</b> Days <b>25</b>	<b>IF UNDER 24 HR</b> Hours <b> </b> Min. <b> </b>
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>In Home</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Summitville, Iowa</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>
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<b>13a. FATHER'S NAME</b> <b>George M. Crofts</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Lucy Sweeney</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>William L. Budlong</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>	<b>16. SOCIAL SECURITY NO.</b> <b>unknown</b>	<b>17. INFORMANT</b> <b>Mrs. Jean H. Northcutt</b> Address <b>Springfield, Mo.</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Dis</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriolar nephrosclerosis</b>	INTERVAL BETWEEN ONSET AND DEATH <b>Several years</b> " " " "
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PART III. If deceased was female was there a pregnancy, in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour <b> </b> a.m. <b> </b> p.m.	Month, Day, Year <b> </b>
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE
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21. I attended the deceased from 2-4-54, to 7-30-59 and last saw her <sup>him</sup> alive on 7-30-59  
 Death occurred at 11:35 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <b>Harold H. Lurie, M.D.</b>	<b>22b. ADDRESS</b> <b>609 Cherry Springfield, Mo.</b>	<b>22c. DATE SIGNED</b> <b>7-31-59</b>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE</b> <b>August 1, 1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Hazelwood</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>Springfield, Missouri</b>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Gorman-Scharpf Funeral Home, Inc.</b> <b>Springfield, Missouri</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>8-3-59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>Effie G. Melton</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed: Lewis Schaeff

Licensed Embalmer No. 3802

P. O. Address: Spring

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
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.