

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024741

FILED VS AUG 1 0 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 820

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Greene			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Length of stay in 1b 39 yrs.		c. CITY OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2415 Benton		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANCIS MARION CLEVINGER				4. DATE OF DEATH Month July Day 31 , Year 1959			
5. SEX Male	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 Oct. 28, 1895	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Welder			10b. KIND OF BUSINESS OR INDUSTRY Frisco		11. BIRTHPLACE (City and state or country) Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Jack Clevenger			13b. MOTHER'S MAIDEN NAME Lorina Pryor		14. NAME OF HUSBAND OR WIFE Blanche		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) Yes W.W. # 1			16. SOCIAL SECURITY NO. 202-07-5275		17. INFORMANT Address Mrs. Blanche Clevenger Spfg., 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) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arteriosclerosis generalized</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 _____ 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 COUNTY _____ STATE _____		
21. I attended the deceased from <u>July 31, 1959</u> to <u>July 31, 1959</u> and last saw him alive on <u>7-31-59</u> Death occurred at <u>4:30</u> A. _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Michael Clarke M.D.</i>				22b. ADDRESS <u>Springfield, Mo</u>		22c. DATE SIGNED <u>8-5-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 3, 1959	23c. NAME OF CEMETERY OR CREMATORY White Chapel		23d. LOCATION (City, town, or county) (State) Springfield, Mo.		
24. FUNERAL DIRECTOR ADDRESS Ralph Thieme F.H. Spfg., Mo. LM			25. DATE RECD. BY LOCAL REG. 8-6-59		26. REGISTRAR'S SIGNATURE <i>Effie G. Melton</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 10 1959

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed

Lee Mason

Licensed Embalmer No. 4568

P. O. Address Springfield, M

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