

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024747

FILED VS AUG 3 1959

Registration District No. 1728 Primary Registration District No. 2000 Registrar's No. 794

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Henry					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Length of stay in lb 21 months		c. CITY OR TOWN Montrose		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1623 Irving st. Foster's Rest Home			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (if outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First FRED Middle R. Last DARNELL				4. DATE OF DEATH Month July Day 25 Year 1959					
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Aug. 3, 1969		9. AGE (last birthday) 89 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and state or country) Illinois		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME Jacob L. Darnell			13b. MOTHER'S MAIDEN NAME Amanda Maash			14. NAME OF HUSBAND OR WIFE Deceased			
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. None		17. INFORMANT Max Darnell Address Louisburg, 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) Arterio-sclerotic Heart Disease								INTERVAL BETWEEN ONSET AND DEATH Not Known	
DUE TO (b) Generalized Arterio-sclerosis								Not Known	
DUE TO (c) _____									
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 12-14-57 to 7-11-59 and last saw ^{him} alive on 7-11-59 Death occurred at 8:15/a m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Albert P. Simpson M.D.				22b. ADDRESS 301 Springfield Med. Bldg. Springfield Mo.				22c. DATE SIGNED 7-27-59	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
Removal & Burial		7-25-59		Montrose Cemetery		Montrose Missouri			
24. FUNERAL DIRECTOR Vansant Funeral Home Clinton, Mo.				25. DATE RECD. BY LOCAL REG. 7-27-59		26. REGISTRAR'S SIGNATURE Effie S. Melton			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 16 1959

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 Ogle Stone Jr.

Licensed Embalmer No. 46

P. O. Address Springfield

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