

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-024756**

FILED VS AUG 3 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 786

STATE FILE NUMBER

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Greene</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Webster</b> |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Springfield</b>   |  | Length of stay in 1b<br><b>14 1/2 Hrs.</b>  |  | c. CITY OR TOWN <b>Marshfield</b>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Ozark Osteopathic Hospital</b>  |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (if outside, give location)<br><b>Route # 1</b>  |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Pamela</b> Middle <b>Jean</b> Last <b>Flanary</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>23</b> Year <b>1959</b>   |  |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>       | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>7/23/59</b>   | 9. AGE (last birthday)<br><b>14</b> Months <b>14</b> Days <b>29</b> Hours <b>29</b> Min. | IF UNDER 1 YEAR  | IF UNDER 24 HR                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>                                     |  | 11. BIRTHPLACE (City and state or country)<br><b>Springfield, Missouri</b>               |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b> |
| 13a. FATHER'S NAME<br><b>Thomas E. Flanary</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Ruby Pauline Johnson</b>                             |  | 14. NAME OF HUSBAND OR WIFE<br><b>none</b>   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or, unknown) <b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>no</b>  |  | 17. INFORMANT<br>Address<br><b>Ruby Flanary, Rt. # 1, Marshfield, Mo.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| IMMEDIATE CAUSE (a) <b>Respiratory failure</b>  |  |   |  |  |  | <b>immediate</b>   |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |  |   |  |  |  |  |  |
| DUE TO (b) <b>Prematurity</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)   |  |   |  |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour <b>4:55</b> a.m. <b>P.</b> Month, Day, Year <b>7/23/59</b>  |  |   |  |  |  |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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 <b>7/23/59</b> , to <b>7/23/59</b> and last saw her him alive on <b>7/23/59</b><br>Death occurred at <b>4:55 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |  |  |  |  |
| 22a. SIGNATURE (Degree or title)<br><b>Dr. Andrew Martiniuk</b>   |  |   |  | 22b. ADDRESS<br><b>700 E. Sunshine Springfield, Mo.</b>  |  | 22c. DATE SIGNED<br><b>7/23/59</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>7/24/59</b>            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bolles Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Laclede Co Mo.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Dorsey Howe Lebanon Mo.</b>  |  |   | ADDRESS<br><b>7-27-59</b>  | 25. DATE RECD. BY LOCAL REG.   | 26. REGISTRAR'S SIGNATURE<br><b>Effie G. Melton</b>                                      |  |  |

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 by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

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

Signed Rowley M. Ho

Licensed Embalmer No. 422

P. O. Address Lebanon

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.