

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024771

FILED VS AUG 17 1959

Registration District No. 228 Primary Registration District No. 2000 Registrar's No. 840B

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Greene b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene c. CITY OR TOWN Springfield Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) 1347 N. Forest Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Length of stay in 1b 34 years		(If outside, give location)	

3. NAME OF DECEASED (Type or print) First JULIA Middle LEONA Last HINDES			4. DATE OF DEATH Month August Day 5 Year 1959			
5. SEX Female	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 January 10, 1884	9. AGE (last birthday) 75	IF UNDER 1 YEAR Months 6 Days 25	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY In Home		11. BIRTHPLACE (City and state or country) Hickory County, Missouri		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Amos F. Hayes		13b. MOTHER'S MAIDEN NAME Susie Scott		14. NAME OF HUSBAND OR WIFE Gus Hinds		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO.		17. INFORMANT Address Gus Hinds Springfield, 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>Hepatic coma</u> DUE TO (b) <u>Decomposing liver disease probably</u> DUE TO (c) <u>due to hepatic's unknown etiology</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Uremia</u>		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

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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>7-31-59</u> to <u>8-5</u> and last saw ^{her} him alive on <u>8-4-59</u> Death occurred at <u>5 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Leola R. Deane M.D.</u>			22b. ADDRESS <u>12th St. Springfield</u>		22c. DATE SIGNED <u>8-5-59</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 8, 1959	23c. NAME OF CEMETERY OR CREMATORY White Chapel	23d. LOCATION (City, town, or county) (State) Springfield, Mo.		
24. FUNERAL DIRECTOR ADDRESS Gorman-Scharpf Funeral Home Springfield, Missouri		25. DATE RECD. BY LOCAL REG. 8-10-59		26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 Lewis Stcharpf

Licensed Embalmer No. 380

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.