

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024774

STATE FILE NUMBER

FILED VS AUG 17 1959 *28*

Registration District No. *2000* Primary Registration District No. *2000* Registrar's No. *851*

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) Springfield		Length of stay in 1b 4 hours		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 Foster Nursing Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1623 Irving		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SUE ELLA HUGHES				4. DATE OF DEATH Month Aug. Day 10, Year 1959				
5. SEX Female	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 June 4, 1884	9. AGE (last birthday) 75	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Forest City, Illinois		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME W. Underwood			13b. MOTHER'S MAIDEN NAME Lula DeMain McCollar			14. NAME OF HUSBAND OR WIFE		
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. 511-12-0079		17. INFORMANT Address Foster Nursing Home Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Likely Myocardial insufficiency							INTERVAL BETWEEN ONSET AND DEATH Unknown	
Conditions, if any, which gave rise to above cause: (a), stating the underlying cause last. DUE TO (b) Likely Coronary sclerosis							"	
DUE TO (c) Likely diabetes mellitus							"	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Known to have diabetes mellitus						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.) UNATTENDED BY A PHYSICIAN				
20c. TIME OF INJURY Hour 4:00 Month Aug. Day 10, Year 1959		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 Springfield, Missouri		COUNTY Greene STATE MO.	
21. I attended the deceased from 4:00 to 4:00 P. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE James F. Amos M.D.			22b. ADDRESS Greene County Health Officer Springfield, Missouri			22c. DATE SIGNED 8-13-59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11 Aug. 1959	23c. NAME OF CEMETERY OR CREMATORY Chanute		23d. LOCATION (City, town, or county) (State) KANS			
24. FUNERAL DIRECTOR R. Thieme F.H. Spfg., Mo. LM			25. DATE RECD. BY LOCAL REG. 8-13-59		26. REGISTRAR'S SIGNATURE Effie S. Melton			

819139 REC
 UNKNOWN DOCUMENT
 511-12-0079
 BY AFFIDAVIT OF Funeral Director
 MEDICAL CERTIFICATION

6861 6 T 90V

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MS AUG 19 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 _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harold Tuttle

Licensed Embalmer No. 507

P. O. Address 1200 Bonwill

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