

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024781

FILED VS AUG 10 1959

Registration District No. 1258 Primary Registration District No. 2000 Registrar's No. 804

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Green</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Polk</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield, Mo</u>		Length of stay in 1b <u>8hrs</u>		c. CITY OR TOWN <u>Bolivar</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>340 E. Olive</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Nannie</u> Middle <u>Frances</u> Last <u>Lightfoot</u>				4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1959</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11/9/1879</u>		9. AGE (last birthday) <u>79</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Chillicothe, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>William H. Baxter</u>			13b. MOTHER'S MAIDEN NAME <u>Nancy England</u>			14. NAME OF HUSBAND OR WIFE <u>Harry Lightfoot Deceased</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss Eline Lightfoot Bolivar, Mo</u> Address				
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>Arteriosclerotic Heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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. <input type="checkbox"/> Yes <input checked="" 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>7/27/59</u> to <u>7/27/59</u> and last saw her alive on <u>7/27/59</u> Death occurred at <u>540</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Thom L. Cochran M.D.</u>				22b. ADDRESS <u>Springfield Mo</u>				22c. DATE SIGNED <u>7/29/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7/30/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		23d. LOCATION (City, town, or county) <u>Bolivar, Mo</u>		(State)	
24. FUNERAL DIRECTOR <u>Paul D. Butler</u> ADDRESS <u>Bolivar, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>8-3-59</u>		26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 3 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

*Paul D Butler*

Licensed Embalmer No. 447

P. O. Address Bolivar

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.