

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024792

FILED VS AUG 3 1959

Registration District No. 728 Primary Registration District No. 2000 Registrar's No. 776 A STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Lawrence</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b <u>10 minutes</u>		c. CITY OR TOWN <u>Mt. Vernon</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>Ozark Osteopathic Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input 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 <u>Perry Albert</u> Middle <u>Mosher</u> Last				4. DATE OF DEATH Month <u>July</u> Day <u>19,</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6/28/15</u>	9. AGE (last birthday) <u>44</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>21</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>	11. BIRTHPLACE (City and state or country) <u>Lawrence Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		
13a. FATHER'S NAME <u>Albert Mosher</u>			13b. MOTHER'S MAIDEN NAME <u>Gertrude Swearingen</u>		14. NAME OF HUSBAND OR WIFE <u>Velma Mosher</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.	17. INFORMANT Address <u>Maybelle Vaughan, 1241 S. Ferguson, City</u>				
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>Acute circulatory failure</u> DUE TO (b) <u>Acute myocardial infarction</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>7 hrs.</u>		
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 <u></u> a.m. <u></u> p.m. Month, Day, Year <u></u>	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>7/19/59</u> , to <u>7/19/59</u> and last saw her him alive on <u>7/19/59</u> Death occurred at <u>3:29 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Andrew Martiniak, D.O.</u>				22b. ADDRESS <u>700 E. Sunshine, Springfield Missouri</u>		22c. DATE SIGNED <u>7/19/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July -21-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brick Church Cemetery</u>		23d. LOCATION (City, town, or county) <u>Mt Vernon Mo.</u>		(State) <u>Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Max L. Forrest Mt Vernon Mo</u>			25. DATE RECD. BY LOCAL REG. <u>7-27-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 4 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 May L. Fossett

Licensed Embalmer No. 425

P. O. Address McVey

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.