

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024803

FILED VS JUL 27 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 769

STATE FILE NUMBER

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|------------------------------------|-----------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Greene | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Greene | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield | | Length of stay in 1b 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 Baptist Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 532 S. Newton | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Robert Leeroy Qualls | | | | 4. DATE OF DEATH July 18-1959 | | Month July | | Day 18 | | Year 1959 | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH July 17-59 | | 9. AGE (last birthday) 0 Months 0 Days 12 Hours 5 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) None | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (City and state or country) Springfield, Missouri | | | 12. CITIZEN OF WHAT COUNTRY USA | | | |
| 13a. FATHER'S NAME Unknown | | | | 13b. MOTHER'S MAIDEN NAME Mary Qualls | | | | 14. NAME OF HUSBAND OR WIFE Unknown None | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address 532 S. Newton Mrs. Mirian Fitzwater: Spgfd, Mo | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Premature Birth | | | | | | | | | | 1 d. | |
| 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 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 7-17-59 to 7-18-59 and last saw <input checked="" type="checkbox"/> him alive on 7-17-59 Death occurred at 3:00 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | |
| 22a. SIGNATURE <i>Urban J. Busiek</i> (Degree or title) M.D. | | | | | | 22b. ADDRESS Professional Bldg Springfield, Mo | | | 22c. DATE SIGNED 7-20-59 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 7-20-59 | | 23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery | | | 23d. LOCATION (City, town, or county) (State) Springfield, Mo. | | | | |
| 24. FUNERAL DIRECTOR AYRE-GOODWIN: Springfield, Mo. | | | | 25. DATE RECD. BY LOCAL REG. 7-21-59 | | 26. REGISTRAR'S SIGNATURE <i>Effie S. Meltzer</i> | | | | | |

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

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.