

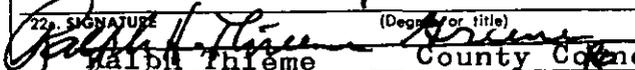
DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024806

FILED VS AUG 10 1959

Registration District No. 1229 Primary Registration District No. 2000 Registrar's No. 839

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Greene County Missouri b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lynn St. at West Ave. Springfield, Mo. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				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 checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 1347 N. Clifton Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lula R. Rose			4. DATE OF DEATH Month Day Year August 5, 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 February 11, 1887 (72)	9. AGE (last birthday) IF UNDER 1 YEAR Months _____ Days _____	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 _____		11. BIRTHPLACE (City and state or country) Springfield, Missouri USA			
13a. FATHER'S NAME John Ray		13b. MOTHER'S MAIDEN NAME Francis Thomas		14. NAME OF HUSBAND OR WIFE Albert Rose (Dec.)			
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. Unknown		17. INFORMANT Address 1451 N. Clifton 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) HEAD AND CHEST INJURIES 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					INTERVAL BETWEEN ONSET AND DEATH INST.		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) PEDESTRIAN FATALITY. HIT BY CAR IN MIDDLE OF 1400 BLOCK N. WEST AVENUE. SHE WAS CROSSING STREET. RAN IN FRONT OF CAR.					
20c. TIME OF INJURY Hour _____ m. Month, Day, Year APROX 10:50 AM 8-5-1959		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street					
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION Springfield, Missouri (greene)		20g. COUNTY Greene			
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at APROX 10:50 AM on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE  (Degree or title) County Coroner			22b. ADDRESS Springfield, Missouri		22c. DATE SIGNED 8-6-59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-8-59		23c. NAME OF CEMETERY OR CREMATORY Hazelwood Cemetery			
24. FUNERAL DIRECTOR AYRE-GOODWIN: SPRINGFIELD, MO.			23d. LOCATION (City, town, or county) (State) Springfield, Missouri		26. REGISTRAR'S SIGNATURE 		
25. DATE RECD. BY LOCAL REG. 8-7-59		26. REGISTRAR'S SIGNATURE 					

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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

Harry Payne

Licensed Embalmer No. 4594

P. O. Address Springfield

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.