

IN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 14 1959

59-028721

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 939

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE. (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Springfield</b>		c. CITY OR TOWN <b>Springfield</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. Burge Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>837 W. Central</b>	

3. NAME OF DECEASED (Type or print) <b>DEWEY HURLEN EARLS</b>			4. DATE OF DEATH <b>September 4, 1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>29 January 1899</b>	9. AGE (last birthday) <b>59</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railway Express Messenger</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (City and state or country) <b>Arkansas</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>David Earls</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Walker</b>	14. NAME OF HUSBAND OR WIFE <b>Helen Earls</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT <b>Paul H. Earls (Son) Durham, N. Carolina</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis, Coronary</b>		INTERVAL BETWEEN ONSET AND DEATH <b>hour</b>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>Myocarditis Chronic</b>		<b>1 1/2 years</b>
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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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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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 <b>Springfield, Missouri</b>	COUNTY <b>Greene</b>	STATE <b>Missouri</b>
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21. I attended the deceased from \_\_\_\_\_ to **9/4/59** and last saw <sup>REF</sup>him alive on **8-30-59**  
Death occurred at **7:00** A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>J. Newton Wakenon MA</b>	(Degree or title)	22b. ADDRESS <b>Woodruff Building Springfield, Missouri</b>	22c. DATE SIGNED <b>9-4-59</b> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>8 Sept. 59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MAPLE PARK CEMETERY</b>	23d. LOCATION (City, town, or county) <b>SPRINGFIELD MISSOURI</b>
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24. FUNERAL DIRECTOR <b>Klingner Mortuary</b>	ADDRESS <b>Springfield, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>9-9-59</b>	26. REGISTRAR'S SIGNATURE <b>Effie G. Melton</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 16 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 Max Phoa

Licensed Embalmer No. 40

P. O. Address Spring

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