

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-028773

**Heimbarger**  
INDEXED

Registration District No. 128 FILED VS SEP 14 1959 200 Primary Registration District No. 200 Registrar's No. 950

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <b>GREENE</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b> Length of stay in 1b <b>5 DAYS</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOHN'S HOSP.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>ARKANSAS</b> b. COUNTY <b>BOONE</b> c. CITY OR TOWN <b>HARRISON</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>ROUTE # 1 HIGHWAY # 7</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>EUGENE GREENVILLE ROUNTREE</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>SEPT. 7 1959</b>							
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>5/12/84</b>		<b>9. AGE (last birthday)</b> <b>75</b>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>ASSNT. OFFICE MGR. RANDOLPH BOX &amp; LABEL CO. NASHVILLE, TENN.</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>NASHVILLE, TENN.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>			
<b>13a. FATHER'S NAME</b> <b>GREENVILLE G. ROUNTREE</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>ANNA TYNDELLE</b>				<b>14. NAME OF HUSBAND OR WIFE</b> <b>CLEMENTINE ROUNTREE</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, NO or unknown) (If yes, give war or dates of service) <b>NO</b>				<b>16. SOCIAL SECURITY NO.</b> <b>325-03-9274</b>		<b>17. INFORMANT</b> Address <b>Rt # 1</b> <b>Clementine Rountree Harrison, Ark.</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, acute, lobar</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Malnutrition</b> DUE TO (c) <b>Gangrene of skin</b> 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 <b>48 hrs.</b>  <b>15 mos.</b>  <b>9 mos.</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>									
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)				<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE							
<b>21. I attended the deceased from</b> <b>9/2/59</b> <b>p.m.</b> , to <b>9/7/59</b> and last saw her/him alive on <b>9 a.m.</b> Death occurred at <b>1:10 p.m.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.											
<b>22a. SIGNATURE</b> (Degree or title) <i>E. Heimbarger M.D.</i>						<b>22b. ADDRESS</b> <b>609 Medical Arts Bldg., Springfield 4, Missouri</b>			<b>22c. DATE SIGNED</b> <b>9/8/59</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>		<b>23b. DATE</b> <b>9/11/59</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ALL SAINTS CEM.</b>			<b>23d. LOCATION</b> (City, town, or county) (State) <b>CHICAGO, ILL</b>				
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>H. H. LOHMEYER SPRINGFIELD, MO.</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <b>9-11-59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Effie G. Melton</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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Gene C. Hunter

Licensed Embalmer No. 4739

P. O. Address Spfld. Mo

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.