

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031984

FILED VS OCT 13 1959/28

Registration District No. 28 Primary Registration District No. 2000 Registrar's No. 1038

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY GREENE			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 39 YRS.	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 BURGE HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1327 E. CENTRAL		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CORA Middle M. Last DARBY			4. DATE OF DEATH Month OCT. Day 2 Year 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 8/7/82	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) HERMITAGE, MO.	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME JESSE STROUD		13b. MOTHER'S MAIDEN NAME SUSAN JOHNSON		14. NAME OF HUSBAND OR WIFE FRANK DARBY (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. NO	17. INFORMANT Address GLENN DARBY 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) Cerebral hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis 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 2 weeks 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 <u>1956</u> , to <u>10/2/59</u> and last saw her/him alive on <u>10/2/59</u> Death occurred at <u>10:35 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) L. Richard Webb, M.D.			22b. ADDRESS 609 Cherry, Springfield, Mo.		22c. DATE SIGNED 10/3/59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10/5/59	23c. NAME OF CEMETERY OR CREMATORY EASTLAWN	23d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO.		
24. FUNERAL DIRECTOR H.H. LOHMEYER		ADDRESS SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 10-5-59	26. REGISTRAR'S SIGNATURE Effie S. Melton	

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 [Signature]

Licensed Embalmer No. 2717

P. O. Address [Signature]

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.