

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032020

FILED VS SEP 28 1959

 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1001

STATE FILE NUMBER

IDED

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 25 years		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 633 Cherry			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1045 Cherry		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ANNA Middle LLOYD Last LLOYD				4. DATE OF DEATH Month September Day 22 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 Feb. 18, 1869	9. AGE (last birthday) 90	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY In Home		11. BIRTHPLACE (City and state or country) Shreveport, Louisiana		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Unknown Dooley			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Robert Wesley Lloyd			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None			16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT O. E. Lloyd			Address 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 Thrombosis DUE TO (b) Hypertensive Cardio-Vascular Disease DUE TO (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH		
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"/> None			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. None	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 9-25-53 to 9-22-59 and last saw her her alive on 9-22-59 Death occurred at 9 A. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE W.D. Carl, M.D. (Degree or title)				22b. ADDRESS 609 Cherry, Springfield, Mo.				22c. DATE SIGNED 9/22/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 24, 1959	23c. NAME OF CEMETERY OR CREMATORY Hazelwood			23d. LOCATION (City, town, or county) Springfield, Missouri (State)				
24. FUNERAL DIRECTOR Gorman-Scharpf Funeral Home Springfield, Missouri ADDRESS				25. DATE RECD. BY LOCAL REG. 9-25-59		26. REGISTRAR'S SIGNATURE Effie S. Meeton			

(Licensed Embalmer's Statement on Reverse Side)

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 L. Saalini Gorn

Licensed Embalmer No. 3177

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.