IRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 28 1959

59–032037
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 986

1. PLACE OF DEATH
a. COUNTY: Greene
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: Burge Hospital
Inside Limits: Yes ☒ No ☐

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 ☒ No ☒
d. STREET ADDRESS (If outside, give location): Rt. 7 Box 425
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: TERESA Middle: ANN Last: OWENS
4. DATE OF DEATH: Month: September Day: 18, Year: 1959
5. SEX: Fe Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 18 Sept. 1959
9. AGE (last birthday): 0
IF UNDER 1 YEAR: Months: 0 Days: 0 IF UNDER 24 HR: Hours: 8 Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: Infant
11. BIRTHPLACE (City and state or country): Springfield, Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: James Owens
13b. MOTHER'S MAIDEN NAME: Barbara Wade
14. NAME OF HUSBAND OR WIFE: None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Hospital Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ATELECTASIS — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): PREMATURITY — 1 Day
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 9/18/59, to 9/18/59 and last saw her/him alive on 9/18/59
Death occurred at 8:15 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Edgar L. Clayton (Degree or title) MD
22b. ADDRESS: 609 Cherry Springfield, Missouri
22c. DATE SIGNED: 9/21/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9/19/59
23c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery
23d. LOCATION (City, town, or county) (State): Springfield, Mo.

24. FUNERAL DIRECTOR: KLINGNER MORTUARY, INC. ADDRESS: Springfield, Mo.
25. DATE RECD. BY LOCAL REG.: 9-24-59
26. REGISTRAR'S SIGNATURE: Effie G. Melton

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 40

P. O. Address _____

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