

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032059

FILED VS OCT 5 1959

Registration District No. 728 Primary Registration District No. 2000 Registrar's No. 1028

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Stone	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Length of stay in 1b 7 years	c. CITY OR TOWN Galena Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Osteopathic Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Route 3 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First	Middle	Last	Month	Day
PEARL			September 29, 1959	

5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1886	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months 1 Days 29 Hours Min. 	IF UNDER 24 HR Hours Min.
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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) Marshfield, Missouri	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME S. G. Bouldin	13b. MOTHER'S MAIDEN NAME Nannie C. Dugan	14. NAME OF HUSBAND OR WIFE Carl W. Swenson
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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.	17. INFORMANT Carl W. Swenson	Address Galena, Missouri
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH HAS CAUSED BY: IMMEDIATE CAUSE (a) Toxic Coma (Toxemia)		INTERVAL BETWEEN ONSET AND DEATH 6 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Acute Hepatic Insufficiency		about 2-3 weeks
	DUE TO (c) Chronic Portal Cirrhosis		unknown
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 checked="" 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"/>	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 Springfield, Mo.	COUNTY Stone	STATE Missouri
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21. I attended the deceased from 9/21/59 to 9/29/59 and last saw her alive on 9/29/59
 Death occurred at 9/29/59 3:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Seland E. Witzel DO	22b. ADDRESS Springfield, Mo.	22c. DATE SIGNED 9/29/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE October 1, 1959	23c. NAME OF CEMETERY OR CREMATORY I. O. O. F.	23d. LOCATION (City, town, or county) (State) Monett, Missouri
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24. FUNERAL DIRECTOR Gorman-Scharpf Funeral Home ADDRESS Springfield, Missouri	25. DATE RECD. BY LOCAL REG. 10-1-59	26. REGISTRAR'S SIGNATURE Effie G. Melton
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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. A. Gorman

Licensed Embalmer No. 3179

P. O. Address Springfield

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.