

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032061

FILED VS. OCT. 5 1959 128

Registration District No. 2000 Primary Registration District No. 2000 Registrar's No. 1000 A

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>WEBSTER</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Length of stay in 1b <b>2 WKS</b>		c. CITY OR TOWN <b>MARSHFIELD MO</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BAPTIST Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>315 W WASHINGTON</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ANN</b> Last <b>TIERNEY</b>				4. DATE OF DEATH Month <b>SEPT</b> Day <b>21</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-19-1876</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET BEAUTICIAN</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
13a. FATHER'S NAME <b>UNKNOWN</b>			13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>498-40-1178</b>		17. INFORMANT <b>HARRY SMITH</b>		Address <b>MARSHFIELD, MO</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b)	
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	
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 <b>9/5/59</b> to <b>9/21/59</b> and last saw her/him alive on <b>9/21/59</b> Death occurred at <b>947 P</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>J. Cochran M D</b> (Degree or title)				22b. ADDRESS <b>Springfield Mo</b>		22c. DATE SIGNED <b>9/25/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>9-25-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MARSHFIELD</b>		23d. LOCATION (City, town, or county) <b>MARSHFIELD MO</b>		(State)	
24. FUNERAL DIRECTOR <b>BARBER-EDWARDS MARSHFIELD MO</b>				ADDRESS	25. DATE RECD. BY LOCAL REG. <b>9-28-59</b>	26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1961  
8 NOV 54

**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 George Stapp

Licensed Embalmer No. 3161

P. O. Address W. H. Brown

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.