

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035774

Dr. H. S. **FILED VS NOV 16 1959**

Registration District No. **128** Primary Registration District No. **2000** Registrar's No. **1201**

STATE FILE NUMBER

MADE

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 1319 CHERRY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1319 CHERRY		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last DR. ALFRED EUGENE ALLDER			4. DATE OF DEATH Month Day Year NOV. 7 1959		
5. SEX MALE	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 2/25/78	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY PHYSICIAN		11. BIRTHPLACE (City and state or country) CEDAR COUNTY, MO.	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME JOHN E. ALLDER		13b. MOTHER'S MAIDEN NAME MARTHA A. PYLE	
14. NAME OF HUSBAND OR WIFE ORAL ALLDER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war & dates of service) YES W.W. # 1		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. ORAL ALLDER, 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) Coronary heart failure		INTERVAL BETWEEN ONSET AND DEATH 8 mo.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Atherosclerotic vascular disease		DUE TO (c) 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 type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 Springfield Greene, Mo			
21. I attended the deceased from Mar 2, 1959 to Nov 7, 1959 and last saw him alive on Nov 5, '59 Death occurred at 1:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>H. S. Lohmeyer MD</i> (Degree or title)		22b. ADDRESS 609 Cherry St.		22c. DATE SIGNED Nov 9 '59	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11/10/59	23c. NAME OF CEMETERY OR CREMATORY EASTLAWN		23d. LOCATION (City, town, or county) SPRINGFIELD, MO.	
24. FUNERAL DIRECTOR H.H. LOHMEYER SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 11-9-59		26. REGISTRAR'S SIGNATURE <i>Effie E. Melton</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS NOV 16 1959 SA

VS OCT 25 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

W. A. McCann

Licensed Embalmer No. 2727

P. O. Address

Springfield, Mo.

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.