URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

Dr. Park FILED VS NOV 16 1959

59–035809
STATE FILE NUMBER

MENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1203

1. PLACE OF DEATH a. COUNTY GREENE b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD — Length of stay in 1b: 30 YRS. c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MERCY HOSP. — 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) 1019 ELM ARCADE — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
DANIEL	CARTER	CURNUTT	NOV.	7	1959

5. SEX	6. COLOR OR RACE	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HR Hours	Min.
MALE	WHITE		4/14/76	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
RETIRED	FARMER	NEWTON COUNTY, ARK.	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
RILEY CURNUTT	MARY JONES	MINTIE CURNUTT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO			BERT CURNUTT,	SPRINGFIELD, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Cerebral Thrombosis due to

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) arteriosclerosis

DUE TO (c) Generalized arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Adenocarcinoma 2 Prostate

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.)
	none	

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
none	

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
none				

21. I attended the deceased from 4-29-57 to November 7, 1959 and last saw him alive on 11-7-59

Death occurred at 12:20 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
W. Paul, M.D.	609 Cherry, Springfield, Mo	11/9/59

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
BURIAL	11/9/59	GREENLAWN	SPRINGFIELD, MO.

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
H.H. LOHMEYER,	SPRINGFIELD, MO.	11-9-59	Effie B. 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 me

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed H. D. McCann

Signature of Student Embalmer

Licensed Embalmer No. 2722

P. O. Address Springfield

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