

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035821

FILED VS. OCT 26 1959

128

Primary Registration District No. 2000

Registrar's No. 1098

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>Green</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Wright</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Length of stay in 1b <b>8 days</b>	c. CITY OR TOWN <b>Mtn. Grove</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Johns Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1 Mi. N/West</b>		
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Monroe</b> Last <b>Fly</b>			4. DATE OF DEATH Month <b>October</b> Day <b>15</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>4/12/1883</b>	9. AGE (last birthday) <b>76</b> IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HR: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>		11. BIRTHPLACE (City and state or country) <b>Mtn. Grove, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>James K. Fly</b>		13b. MOTHER'S MAIDEN NAME <b>Leona Jane Files</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Eldora Yocum Mtn. Grove, Missouri</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>Cerebral Hemorrhage</b> DUE TO (b) <b>Cerebral arterio-sclerosis</b> DUE TO (c) <b>Generalized Arterio-sclerotic heart disease</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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					INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>	
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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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>10-7-59</b> to <b>10-15-59</b> and last saw him alive on <b>10-15-59</b> Death occurred at <b>3:45 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>G. H. Terrell</b> (Degree or title) <b>Dr. D</b>			22b. ADDRESS <b>302 Prof. Bldg Springfield Mo</b>		22c. DATE SIGNED <b>10/19/59</b> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-17-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Old Hillcrest Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Mtn. Grove, Missouri</b>		
24. FUNERAL DIRECTOR <b>Evell C. Craig</b> ADDRESS <b>Mtn. Grove, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>10-22-59</b>		26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 5 1961

**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 Lewell C. Cronig

Licensed Embalmer No. 4766

P. O. Address Mt. Grove

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.