

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-035839**

**DR. POLK**

FILED VS NOV 9 1959

STATE FILE NUMBER

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 1178

ENDED

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		Length of stay in 1b <u>2 YRS.</u>		c. CITY OR TOWN <u>SPRINGFIELD</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOHN'S HOSP.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2232 E. LANGSTON</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AMELIA</u> Middle <u>HENZI</u> Last				4. DATE OF DEATH Month <u>NOV.</u> Day <u>1</u> Year <u>1959</u>					
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1/9/77</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 24 HR Hours	IF UNDER 24 HR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>UNION CITY, N.J.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>(unknown) KOVERMANN</u>			13b. MOTHER'S MAIDEN NAME <u>(Unknown)</u>			14. NAME OF HUSBAND OR WIFE <u>LOUIS HENZI (DEC.)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>MRS. WALTER HUBSMITH, SPRINGFIELD, MO.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident, left</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
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 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 <u>11/1/59</u> to <u>11/1/59</u> and last saw <sup>her</sup> <del>him</del> alive on <u>11/1/59</u> Death occurred at <u>11:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>John W. Palk, MD</u>				22b. ADDRESS <u>604 Med. Arts Bldg. Springfield, Mo.</u>				22c. DATE SIGNED <u>11/2/59</u>	
23a. BURIAL / CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>11/3/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WEEHAWKEN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>UNION CITY, N.J.</u>				
24. FUNERAL DIRECTOR <u>H.H. LOHMEYER SPRINGFIELD, MO.</u>				25. DATE RECD. BY LOCAL REG. <u>11-4-59</u>		26. REGISTRAR'S SIGNATURE <u>Effie S. Mellow</u>			

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 me

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Pauls E. Schu

Licensed Embalmer No. 2451

P. O. Address Apple St

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.