

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035904

Dr. Dillard

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 1131

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Length of stay in 1b <b>3 MO.</b>	c. CITY OR TOWN <b>SPRINGFIELD</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>KIMBROUGH REST HOME</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>704 W. TRACY</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>TEIBER</b> Last			4. DATE OF DEATH Month <b>OCT.</b> Day <b>21</b> Year <b>1959</b>			
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/28/84</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>SANTANNA, HUNGARY</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>(UNKNOWN) WILLE</b>	13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE <b>GEORGE J. TEIBER (DEC.)</b>
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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.	17. INFORMANT <b>ANTHONY TEIBER</b> Address <b>SPRINGFIELD, MO.</b>
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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 vascular accident secondary to arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH
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) <b>Fracture, intracapsular, femur, left.</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>Fell at home 8 September 1959</b>
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20c. TIME OF INJURY Hour <b>Sept 8, 1959</b> s.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>about home</b>	20f. CITY, TOWN, OR LOCATION <b>Springfield, Missouri</b> COUNTY <b>Greene</b> STATE <b>Missouri</b>
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21. I attended the deceased from <b>8 Sept 59</b> to <b>24 Sept 59</b> and last saw her/him alive on <b>24 Sept 59</b> Death occurred at <b>11 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>Dr. M. Dillard M.D.</i> (Degree or title)	22b. ADDRESS <b>Springfield, Missouri</b> <b>103 Professional Building</b>	22c. DATE SIGNED <b>22 Oct 59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>10/24/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPH CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>EBLOOMINGTON, ILL.</b>
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24. FUNERAL DIRECTOR <b>H.H. LOHMEYER</b> ADDRESS <b>SPRINGFIELD, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>10-23-59</b>	26. REGISTRAR'S SIGNATURE <i>Effie S. Meekins</i>
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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 Walter E Hamella

Licensed Embalmer No. 3808

P. O. Address Springfield

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.