

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038705

FILED VS OCT 27 1959 360

6225

171

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>Vernon</b> <b>Vernon</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>Washington</b>		Length of stay in 1b	c. CITY OR TOWN <b>Springfield</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Nevada State Hospital #3</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2300 W. Walnut</b>
		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>J.</b> Last <b>James</b>			4. DATE OF DEATH Month <b>10-</b> Day <b>18-</b> Year <b>1959</b>			
5. SEX <b>Male</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>Unknown</b>	9. AGE (last birthday) <b>88</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (City and state or country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>William James</b>		13b. MOTHER'S MAIDEN NAME <b>Catherine Johns</b>			14. NAME OF HUSBAND OR WIFE <b>Unknown</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>	16. SOCIAL SECURITY NO. <b>448-28-7948</b>	17. INFORMANT <b>Adm Papers</b>	Address
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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>Coronary Vessel Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>3rd. Day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Fractured Right Hip</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>Senil Dementia</b>		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	
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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.) <b>While getting out of bed, fell.</b>	
20c. TIME OF INJURY Hour <b>2:10</b> a.m. <b>10/18/58</b> p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, factory, store, office bldg., etc.) <b>Hosp. ward</b>	20f. CITY, TOWN, OR LOCATION <b>State Hosp. #3 Nevada, Mo.</b>	

21. I attended the deceased from **2-8-159** **10-18-59** and last saw <sup>xxx</sup>him alive on **10-18-59**  
Death occurred at **3 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>E. Allen Pickens, M.D.</b>	22b. ADDRESS <b>Nevada, Mo.</b>	22c. DATE SIGNED <b>10-18-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10/18/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Christopher Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Murphsboro, Illinois</b>
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24. FUNERAL DIRECTOR <b>Garman-Scharph, Springfield, Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>Oct 20-1959</b>	26. REGISTRAR'S SIGNATURE <b>Anna E. Perry</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 Rercy F. Milster

Licensed Embalmer No. 4885  
P. O. Address Leicester, Ma

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.