

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 23 1959

59-039665

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1249

| | | | | | | | |
|--|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Greene</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Greene</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Springfield</u> | | Length of stay in lb <u>70yrs</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>Handley Hospital</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>1011 1/2 N Texas</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>CLYDE</u> Last <u>HOWARD</u> | | | | 4. DATE OF DEATH Month <u>November</u> Day <u>18</u> Year <u>1959</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Nov '28 1888</u> | 9. AGE (last birthday) <u>71</u> | 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) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Common</u> | | 11. BIRTHPLACE (City and state or country) <u>Springfield Mo</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>unknown</u> | | 13b. MOTHER'S MAIDEN NAME <u>unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>none</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>unknown</u> | | 17. INFORMANT <u>Handley City Hospital record</u> Address _____ | | | |
| 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 apoplexy</u> | | | | | | | 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 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 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 _____ 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>11/15/59</u> to <u>11/18/59</u> and last saw him alive on <u>11/18/59</u> Death occurred at _____ m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Lyman D. Brown M.D.</u> | | | | 22b. ADDRESS <u>311 1/2 College</u> | | 22c. DATE SIGNED <u>11/19/59</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>Nov '20 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Medical School, Columbia</u> | | 23d. LOCATION (City, town, or county) <u>Mo</u> | | |
| 24. FUNERAL DIRECTOR <u>H V Smith 602 N Jefferson St.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>11-20-59</u> | | 26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</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 Herbert V. Smith

Licensed Embalmer No. 4586

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.