

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

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REGISTRATION DISTRICT NO. 128 PRIMARY REGISTRATION DISTRICT NO. 2000 REGISTRAR'S NO. 1339 STATE FILE NUMBER

FILED VS DEC 21 1959

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>10 years</b>	c. CITY OR TOWN <b>Springfield</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. Burge Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2135 E. Cairo</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>HENRY</b> Last <b>CURBOW</b>			4. DATE OF DEATH Month <b>December</b> Day <b>8,</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/27/1874</b>	9. AGE (last birthday) <b>85</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Stone County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME <b>Joseph Curbow</b>		13b. MOTHER'S MAIDEN NAME <b>Susannah Sanders</b>		14. NAME OF HUSBAND OR WIFE <b>Betty Curbow</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>- - - - -</b>	17. INFORMANT <b>Betty Curbow, 2135 E. Cairo, Springfield, Mo.</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>Likely Cerebral artery damage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Likely Cerebral arteriosclerosis</b>		"
DUE TO (c) <b>UNATTENDED BY A PHYSICIAN</b>		

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	
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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.)		
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 11:50 to A. and last saw her him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) <b>James P. Amos, M.D. Greene Co. Health Officer</b>		22b. ADDRESS <b>Greene Co. Health Office, Springfield, Mo</b>		22c. DATE SIGNED <b>12-16-59</b>
23a. FUNERAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/10/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Missouri</b>	
24. FUNERAL DIRECTOR <b>Ralph Thieme, Springfield, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12-16-59</b>	26. REGISTRAR'S SIGNATURE <b>Officer S. Melton</b>	

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 Harold Futrell

Licensed Embalmer No. 5079

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.