

# URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 8 9 4

Dr. Fitch FILED VS DEC 21 1959

STATE FILE NUMBER

Registration District No. 228 Primary Registration District No. 2000 Registrar's No. \_\_\_\_\_

RENDERED

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>		c. CITY OR TOWN <b>SPRINGFIELD</b>	
Length of stay in 1b <b>80 YRS.</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>ST. JOHN'S HOSP.</b>		d. STREET ADDRESS (If outside, give location) <b>1862 E. BROADMOOR</b>	
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>W.</b> Last <b>DENT</b>			4. DATE OF DEATH <b>DEC. 15 1959</b> Month <b>DEC.</b> Day <b>15</b> Year <b>1959</b>			
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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>5/14/71</b>	9. AGE (last birthday) <b>88</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>RETIRED CONDUCTOR</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>FRISCO R.R.</b>	11. BIRTHPLACE (City and state or country) <b>IMBODEN, ARKANSAS</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>CHARLES DENT</b>	13b. MOTHER'S MAIDEN NAME <b>MARY JONES</b>	14. NAME OF HUSBAND OR WIFE <b>ANNA C. DENT (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. <b>?</b>	17. INFORMANT <b>MRS. LEO BUSCH, SPRINGFIELD, MO.</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>Acute Pulmonary Embolism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>
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 of hip.</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 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 on floor of home</b>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <b>12-6-59</b>
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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>Home</b>	20f. CITY, TOWN, OR LOCATION <b>Springfield</b> COUNTY <b>Greene</b> STATE <b>Mo</b>
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21. I attended the deceased from <b>12-6-59</b> to <b>12-15-59</b> and last saw her/him alive on <b>12-14-59</b> . Death occurred at <b>1:40 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Max Ketch</b> (Degree or title) <b>MD</b>	22b. ADDRESS <b>Springfield Mo</b>	22c. DATE SIGNED <b>12-16-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>12/17/59</b>	23c. NAME OF CEMETERY OR CREMATOR <b>GREENLAWN</b>	23d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD, MO.</b>
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24. FUNERAL DIRECTOR <b>H.H. LOHMEYER, SPRINGFIELD, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>12-17-59</b>	26. REGISTRAR'S SIGNATURE <b>Effie G Meeter</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 28 1953

**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 W L McCann

Licensed Embalmer No. 2727

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.