

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

'59 043951

FILED VS DEC 21 1959 28

STATE FILE NUMBER

Registration District No. 228 Primary Registration District No. 2000 Registrar's No. 1343

ENDED

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>WEBSTER</b>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Length of stay in 1b <b>1 DAY</b>		c. CITY OR TOWN <b>SEYMOUR</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>BAPTIST Hosp</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DOLE</b> Middle <b>TRAVIS</b> Last <b>RHODES</b>				4. DATE OF DEATH <b>Dec. 12 - 10 - 59</b>						
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>8-3-1872</b>		9. AGE (last birthday) <b>87</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>Business Woman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>			11. BIRTHPLACE (City and state or country) <b>MTN. HOME ARK.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>THOMAS T. TRAVIS</b>			13b. MOTHER'S MAIDEN NAME <b>REBECCA HAND</b>			14. NAME OF HUSBAND OR WIFE <b>deceased</b>				
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>499-44-3786</b>		17. INFORMANT <b>MRS. DORIS MCMAHAN SEYMOUR MO</b>				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) <b>Coronary Thrombosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</b>								<b>2 yrs</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)						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 <b>12-9-59</b> to <b>12-10-59</b> and last saw <sup>her</sup> alive on <b>12-10-59</b> Death occurred at <b>(3) P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <b>Dorothy Mae</b>				22b. ADDRESS <b>Springfield mo</b>				22c. DATE SIGNED <b>12-14-59</b>		
23a. BURIAL-CREMAATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12-13-59</b>		23c. NAME OF CEMETERY OR CREMAATION <b>SEYMOUR MASONIC CEMETERY WEBSTER CO. MO.</b>		23d. LOCATION (City, town, or county) (State)				
24. FUNERAL DIRECTOR <b>Robert Bergman Seymour, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>12-15-59</b>		26. REGISTRAR'S SIGNATURE <b>Effie 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 Max L Miller

Licensed Embalmer No. 4720

P. O. Address Manfield M

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.