

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 28 1959

59 043962

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1384

1. PLACE OF DEATH a. COUNTY <u>Greene</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> Length of stay in 1b _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1519 W. Lynn</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1519 W. Lynn</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZABETH</u> Last <u>TWIGG</u>			4. DATE OF DEATH Month <u>December</u> Day <u>19</u> , Year <u>1959</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>29 Aug. 1894</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	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) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Henry East</u>	13b. MOTHER'S MAIDEN NAME <u>Rebecca Lee</u>	14. NAME OF HUSBAND OR WIFE <u>Henry Twigg</u>
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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) No <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT Address <u>Hospital Records</u>
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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) <u>Hypertensive arteriosclerotic heart disease</u> DUE TO (b) _____ DUE TO (c) <u>Uremia, terminal</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2-3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>g.i. tract hernia on large, cause unknown</u>		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.)
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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 April 1958 to 12/19/59 and last saw her him on 12/19/59
 Death occurred at 7:50 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Harris E. Kuehl, MD</u> (Degree or title)	22b. ADDRESS <u>1630 N. Jefferson</u> <u>Springfield, Missouri</u>	22c. DATE SIGNED <u>12/21/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/22/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>	23d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>
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24. FUNERAL DIRECTOR <u>KLINGNER MORTUARY, INC. SPRINGFIELD MO.</u>	ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>12-22-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie B. Meston</u>
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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 _____
or by _____; Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Max Hoden

Licensed Embalmer No. 4071

P. O. Address Spring

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.