

# I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000995

FILED VS JAN 25 1960

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 22

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Greene</b>				<b>2. USUAL RESIDENCE</b> (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		c. CITY OR TOWN <b>Willard</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>Burge Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>None</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>RAY ATWOOD</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>January 17, 1960</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>3 April 1904</b>	<b>9. AGE (last birthday)</b> <b>55</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Self Employed</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>	
<b>13a. FATHER'S NAME</b> <b>O.W. Atwood</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Ruth Huff</b>			<b>14. NAME OF HUSBAND OR WIFE</b> <b>Deceased</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) No No			<b>16. SOCIAL SECURITY NO.</b> <b>488-24-1752</b>		<b>17. INFORMANT</b> <b>Hospital Records</b>			Address
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma right lung with metastasis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</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)						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		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour a.m. p.m.		Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>			COUNTY		STATE	
<b>21. I attended the deceased from</b> <u>30 JUNE 1959</u> to <u>1/17/60</u> and last saw <sup>him</sup> <del>her</del> alive on <u>1/17/60</u> Death occurred at <u>8:45</u> a_m on the date stated above, and to the best of my knowledge, from the causes stated.								
<b>22a. SIGNATURE</b> <i>John W. Pock MD</i> (Degree or title)				<b>22b. ADDRESS</b> <b>Medical Arts Building</b>			<b>22c. DATE SIGNED</b> <b>1-19-60</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE</b> <b>1/19/60</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Greenlawn Cemetery</b>			<b>23d. LOCATION</b> (City, town, or county) (State) <b>Springfield, Missouri</b>		
<b>24. FUNERAL DIRECTOR</b> <b>KLINGNER MORTUARY, INC.</b>			ADDRESS <b>SPRINGFIELD MO.</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>1-20-60</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Effie E. Melton</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 10 1960

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 Ogle Stone Jr

Licensed Embalmer No. 4176

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.