

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001051

FILED VS. FEB 15 1960 / 28

Registration District No. \_\_\_\_\_ Primary Registration District No. 2000 Registrar's No. 157 STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Greene</b>  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b> Length of stay in 1b _____  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"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>  c. CITY OR TOWN <b>Springfield</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  d. STREET ADDRESS (If outside, give location) <b>923 E. Pacific</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <b>KATE</b> Middle <b>S.</b> Last <b>ELLINGTON</b>	<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>5,</b> Year <b>1960</b>
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<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>24 Aug. 1866</b>	<b>9. AGE (last birthday)</b> <b>93</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Missouri</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>
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<b>13a. FATHER'S NAME</b> <b>George Hubbell</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Smith</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Deceased</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>	<b>17. INFORMANT</b> Address <b>Edna VanHook (Daughter) Springfield, Mo.</b>
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<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</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	INTERVAL BETWEEN ONSET AND DEATH   
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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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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" 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.)
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<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"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>
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<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>	<b>COUNTY</b>	<b>STATE</b>
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**21. I attended the deceased from** Jan 14, 1960 to 2/5/60 and last saw her alive on 2/5/60  
**Death occurred at** 7:15 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <i>Samuel E. Knapp M.D.</i>	<b>22b. ADDRESS</b> <b>1630 N. Jefferson Springfield, Missouri</b>	<b>22c. DATE SIGNED</b> <b>6 Feb 60</b>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE</b> <b>2/8/60</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Eastlawn Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>Springfield, Missouri</b>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>KLINGNER MORTUARY, INC. Springfield, Mo.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>2-10-60</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Effie S. Melton</i>
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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 Mal Hood

Licensed Embalmer No. 4071

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.