

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001106

FILED VS FEB 8 1960 128

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 141

STATE FILE NUMBER

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>		Length of stay in 1b	c. CITY OR TOWN <b>Springfield</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Texas Hotel</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>334 N. Main</b>
3. NAME OF DECEASED (Type or print) <b>GEORGE FRANCIS McDermott</b>		First Middle Last	4. DATE OF DEATH <b>February 2, 1960</b>

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>20 May 1897</b>	9. AGE (last birthday) <b>62</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LABORER</b>		11. BIRTHPLACE (City and state or country) <b>NEB.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>

13a. FATHER'S NAME <b>JAMES M<sup>c</sup>DERMOTT</b>	13b. MOTHER'S MAIDEN NAME <b>JANE DONOHUE</b>	14. NAME OF HUSBAND OR WIFE <b>DIVORCED</b>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWI</b>	16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT <b>PAUL M<sup>c</sup>DERMOTT (SON)</b> Address <b>OMAHA, NEB.</b>
--	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>Likely Coronary Occlusion</b>	<b>Unknown</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Likely Coronary Sclerosis</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>Likely Severe upper Respiratory Infection</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
--	--	--

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 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 **UNATTENDED BY PHYSICIAN** and last saw her/him alive on \_\_\_\_\_  
 Death occurred at **2:30 P.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>James P. Chas. M.D.</b> (Degree or title)	22b. ADDRESS <b>Greene County Health Officer Springfield, Missouri</b>	22c. DATE SIGNED <b>2-4-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>2/3/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>
24. FUNERAL DIRECTOR ADDRESS <b>KLINGNER MORTUARY, INC. Springfield, Mo.</b>		23d. LOCATION (City, town, or county) (State) <b>Omaha, Nebraska</b>

25. DATE RECD. BY LOCAL REG. <b>2-4-60</b>	26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>
--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 24 1980

FEB 15 1980

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 J. B. Klugner  
Licensed Embalmer No. 335

P. O. Address \_\_\_\_\_

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.