

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-001112

FILED VS. JAN 25 1960 128

Primary Registration District No. 2000 Registrar's No. 70

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b		c. CITY OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input 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>1515 W. Webster</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Lawrence</u> Last <u>Mayden</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>17,</u> Year <u>1960</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3-14-1880</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army Career</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Army</u>		11. BIRTHPLACE (City and state or country) <u>Christian County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		
13a. FATHER'S NAME <u>Arch Mayden</u>			13b. MOTHER'S MAIDEN NAME <u>-?- Hale</u>			14. NAME OF HUSBAND OR WIFE <u>none</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes 1919-20</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Frank Mayden, Springfield, Mo.</u>				
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>Thrombosis, Cerebral</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Arterio-sclerotic Heart Disease</u>								year	
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 _____ Month, Day, Year _____ p.m.									
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 <u>1958</u> to <u>1-17-60</u> and last saw him alive on <u>1-17-60</u> Death occurred at <u>6:00</u> h. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>J. Newton Wakeman MD</u> (Degree or title)				22b. ADDRESS <u>Springfield, Mo</u>		22c. DATE SIGNED <u>1-19-60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-19-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sparta Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Sparta, Missouri</u>					
24. FUNERAL DIRECTOR <u>Rex Rainey, Springfield, Mo.</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>1-20-60</u>		26. REGISTRAR'S SIGNATURE <u>Effie E. Drayton</u>		

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF Informant

FEB 29 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 _____

Licensed Embalmer No. 4568

P. O. Address _____

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.