

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-001114

LED VS FEB 8 1960 128 Primary Registration District No 2000 Registrar's No. 136

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 <b>17 years</b>	c. CITY OR TOWN <b>Springfield</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>St John's Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2621 W. Page</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>FLOYD MESSENGER</b>			4. DATE OF DEATH Month Day Year <b>February 1, 1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 20, 1911</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Orderly</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	9. AGE (last birthday) <b>48</b> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
13a. FATHER'S NAME <b>Ben Messenger</b>		13b. MOTHER'S MAIDEN NAME <b>Mary (unknown)</b>	14. NAME OF HUSBAND OR WIFE <b>Edith Messenger</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>Mrs Edith Messenger, Springfield, Mo.</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypoglycemia</b> DUE TO (b) <b>Insulin</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes mellitus, gland arteriosclerosis</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 checked="" type="checkbox"/> NO <input 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 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 <b>1946</b> to <b>2-1-60</b> and last saw <sup>her</sup> him alive on <b>1-15-60</b> Death occurred at <b>5:30 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>E. B. Lemmon MD</b> (Degree or title)		22b. ADDRESS <b>Springfield, Mo.</b>	22c. DATE SIGNED <b>2-1-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Feb 5, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>East Lawn</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Mo</b>
24. FUNERAL DIRECTOR <b>Jewell E. Windle, Springfield, Mo.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>2-4-60</b>	26. REGISTRAR'S SIGNATURE <b>Effie E. Meeton</b>

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

JUN 1 1960

MAR 4 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 Bernard F. Wright

Licensed Embalmer No. 4293

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.