

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001127

FILED VS JAN 11 1960 28

Registration District No. 28 Primary Registration District No. 200 Registrar's No. 23

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 60 YRS.		c. CITY OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION CONNELLY REST HOME			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1602 N. GRANT			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LILLIAN Middle O'HARA Last O'HARA				4. DATE OF DEATH Month JAN. Day 6 Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10/27/83	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) KNOXVILLE, TENN'RI		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME WASHINGTON E. SMITH			13b. MOTHER'S MAIDEN NAME SARAH WILLIAMS		14. NAME OF HUSBAND OR WIFE LUCIEN O'HARA (DEC.)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT Address MAX L. O'HARA, DALLAS, TEXAS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis						INTERVAL BETWEEN ONSET AND DEATH 1 week	
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	
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 _____ a.m. _____ 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 August 1959 to Jan. 1960 and last saw her alive on 1-6-60 Death occurred at 5:20 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Max L. O'Hara</i>			22b. ADDRESS M. D. Springfield Mo.		22c. DATE SIGNED 1-8-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 1/9/60	23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY		23d. LOCATION (City, town, or county) SPRINGFIELD, MO.			(State)
24. FUNERAL DIRECTOR H.H. LOHMEYER, SPRINGFIELD, MO.			25. DATE RECD. BY LOCAL REG. Jan 8, 1960		26. REGISTRAR'S SIGNATURE <i>Effie G. Melton</i>		

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 H. McQuinn

Licensed Embalmer No. 2727

P. O. Address H. McQuinn

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.