

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001141

FILED VS. JAN 18 1960 128

Registration District No. 128 Primary Registration District No. 2002 Registrar's No. 42

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Greene b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield Length of stay in 1b 58 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene c. CITY OR TOWN Springfield, Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 409 E. Loren Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		(If outside, give location)	

3. NAME OF DECEASED (Type or print) First GEORGE Middle ALBERT Last SCHARPF			4. DATE OF DEATH Month January Day 10, Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1882	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months 10 Day 4 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer Retired		10b. KIND OF BUSINESS OR INDUSTRY Food Market		11. BIRTHPLACE (City and state or country) Prairie DuChien, Wisconsin		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Frederick Scharpf		13b. MOTHER'S MAIDEN NAME Emma Wiebrecht		14. NAME OF HUSBAND OR WIFE Laura M. Scharpf		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Laura M. Scharpf Springfield, Mo.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 2-3-4-5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100 (If deceased was female was there a pregnancy in last 90 days.) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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.

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. 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 <u>1950</u> to <u>1960</u> and last saw her <u>1-10-60</u> alive on _____ at <u>6 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>[Signature]</u> M.D.			22b. ADDRESS <u>Springfield, Mo.</u>		22c. DATE SIGNED <u>1-11-60</u>
23a. BURIAL, CREATION, REMOVAL (Specify) Burial		23b. DATE Jan. 12, 1960	23c. NAME OF CEMETERY OR CREMATORY Maple Park		23d. LOCATION (City, town, or county) (State) Springfield, Missouri
24. FUNERAL DIRECTOR Gorman-Scharpf Funeral Home Springfield, Missouri			25. DATE RECD. BY LOCAL REG. 1-11-60		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

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 L. Edwin Gorman

Licensed Embalmer No. 3177

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.