

PRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001186

FILED VS JAN 25 1960

Registration District No. 128 Primary Registration District No. _____ Registrar's No. 75 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>		c. CITY OR TOWN <u>Springfield</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sunshine Acres Rest Home</u>		d. STREET ADDRESS (If outside, give location) <u>Sunshine Acres Rest Home</u>	
3. NAME OF DECEASED (Type or print) First <u>LEO</u> Middle <u>M.</u> Last <u>FATH</u>		4. DATE OF DEATH Month <u>January</u> Day <u>18,</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 type="checkbox"/>	8. DATE OF BIRTH <u>28 May 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Battery Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE (last birthday) <u>83</u>
11. BIRTHPLACE (City and state or country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Leonard Fath</u>		13b. MOTHER'S MAIDEN NAME <u>Laura Marshall</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT Address <u>Rest Home Records</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) Hypostatic Pneumonia

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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE

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 _____
a.m. _____ p.m. _____

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

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 1958 to 1/18/60 and last saw ^{her} him alive on Jan 13, 1960
Death occurred at 7:30 Am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)
Lyman D. Brown M.D.

22b. ADDRESS
311 1/2 College Springfield, Missouri

22c. DATE SIGNED
1/19/60

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

23b. DATE
JAN 20, 1960

23c. NAME OF CEMETERY OR CREMATORY
Greenlawn Cemetery

23d. LOCATION (City, town, or county) (State)
Springfield, Missouri

24. FUNERAL DIRECTOR
KLINGNER MORTUARY, INC. SPRINGFIELD MO.

25. DATE RECD. BY LOCAL REG.
1-20-60

26. REGISTRAR'S SIGNATURE
Effie S. Melton

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 Ogle Stone Jr.

Licensed Embalmer No. 4176

P. O. Address Springfield

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.