

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005824

Clark & Moseley

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 239

STATE FILE NUMBER

INDEXED

FILED VS MAR 7 1960

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 40 YRS.	c. CITY OR TOWN SPRINGFIELD Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2662 LUSTER Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last H. DWIGHT CARSON			4. DATE OF DEATH Month Day Year FEB. 26 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 11/28/19	9. AGE (last birthday) 40	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER & OPERATOR-	10b. KIND OF BUSINESS OR INDUSTRY IDEAL TIRE SHOP	11. BIRTHPLACE (City and state or country) GREENE COUNTY, MO.	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME HOMER CARSON	13b. MOTHER'S MAIDEN NAME ZELLA RINGENBURG	14. NAME OF HUSBAND OR WIFE RAMAH CARSON	

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. 500-05-0227	17. INFORMANT MRS. RAMAH CARSON, SPRINGFIELD, MO.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral Vascular collapse Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral anoxia DUE TO (c) Cerebrovascular Accident (during surgery)		INTERVAL BETWEEN ONSET AND DEATH
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 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 1-2-60 to 2-26-60 and last saw her/him alive on 2-26-60
Death occurred 10:10 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>F. Thomas Moseley M.D.</i>	22b. ADDRESS <i>Springfield Mo</i>	22c. DATE SIGNED <i>2-29-60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 2/29/60	23c. NAME OF CEMETERY OR CREMATORY MAPLE PARK
23d. LOCATION (City, town, or county) SPRINGFIELD, MO.		(State)

24. FUNERAL DIRECTOR H.H. LOHMEYER,	ADDRESS SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 3-2-60	26. REGISTRAR'S SIGNATURE <i>Effie S. Merton</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAR 8 1960

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. J. McCombs

Licensed Embalmer No. 272

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.