

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 16 1960

=60-014795

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 532

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		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 1650 E. Central			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1650 E. Central		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Nettie Middle L. Last Baker				4. DATE OF DEATH Month May Day 5 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 14 Aug. 1878		9. AGE (last birthday) 81		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Arkansas		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME Shadrach Dennis				13b. MOTHER'S MAIDEN NAME Martha Taylor				14. NAME OF HUSBAND OR WIFE Deceased					
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 Loyd Baker (Son) Springfield, Mo.				Address 1015 N. Fremont			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure										INTERVAL BETWEEN ONSET AND DEATH 1 Month			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Atherosclerosis										10 year			
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 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 5-10-55 to 5/5/60 and last saw ^{her} _{him} alive on 5-5-60 Death occurred at 4:00 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE Earl D. Russell M.D. (Deceased or title)				22b. ADDRESS 1503 S. Glenstone Springfield, Missouri				22c. DATE SIGNED 5-9-60					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-9-60		23c. NAME OF CEMETERY OR CREMATORY Danforth Cemetery		23d. LOCATION (City, town, or county) (State) Greene County, Missouri							
24. FUNERAL DIRECTOR Klingner Mortuary ADDRESS Springfield, Mo.				25. DATE RECD. BY LOCAL REG. 5-11-60		26. REGISTRAR'S SIGNATURE Effie E. Mellow							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

jhc

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

May Phod

Licensed Embalmer No. 407

P. O. Address Phung

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.