

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 18 1960

=60-014836

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 407

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 St. Johns Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 711 Old Orchard		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle RODNEY Last FOLLIS			4. DATE OF DEATH Month April Day 8 Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 15 Oct. 1956	9. AGE (last birthday) 3	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child			10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Louisiana		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Richard H. Follis			13b. MOTHER'S MAIDEN NAME Carol Hennell		14. NAME OF HUSBAND OR WIFE None		
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 711 Old Orchard Carol Follis (Mother) 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) Cerebral Thrombosis						INTERVAL BETWEEN ONSET AND DEATH immediat	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Renal carcinoma, Rt						3 wks	
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.	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 4-6-60 to 4/8/60 and last saw ^{her} him alive on 4/8/60 Death occurred at 1:50 P.m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (If agree or file) William F. Johnson, M.D.			22b. ADDRESS 609 Cherry Springfield, Missouri			22c. DATE SIGNED 4-11-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/11/60	23c. NAME OF CEMETERY OR CREMATORY White Chapel Cemetery		23d. LOCATION (City, town, or county) (State) Springfield, Missouri			
24. FUNERAL DIRECTOR Klingner Mortuary			ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 4-14-60	26. REGISTRAR'S SIGNATURE Effie B. Melton		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

5c

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

Max Phade

Licensed Embalmer No. 4021

P. O. Address *Spring*

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.