

**R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-014845**

**FILED VS APR 18 1960**

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 392A STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Greene</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Green</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield, Mo</u>		Length of stay in 1b <u>2 Years</u>	c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>I034 "</u> (If outside, give location) <u>Montoe</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print) First <u>Zula</u> Middle <u>Gaston</u> Last <u>Gaston</u>			<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>3</u> Year <u>1960</u>	
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<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>4/3/1876</u>	<b>9. AGE</b> (last birthday) <u>84</u>	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	<b>IF UNDER 24 HR</b> Hours <u>  </u> Min. <u>  </u>
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (City and state or country) <u>Christian Co, Mo</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U S A</u>
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<b>13a. FATHER'S NAME</b> <u>George Cowan</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Sara Patterson</u>	<b>14. NAME OF HUSBAND OR WIFE</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT</b> Address <u>Edna Cowan, I034 Montoe, Springfield, Mo</u>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>		<u>1 week</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive Cardiovascular Disease 5 yrs.</u>	
	DUE TO (c)	

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)	<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour <u>  </u> Month, Day, Year <u>  </u>	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE
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<b>21. I attended the deceased from</b> <u>1957</u> to <u>March 26, 1960</u> and last saw her/him alive on <u>March 26, 1960</u> Death occurred at <u>April 4/1960-III 5 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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<b>22a. SIGNATURE</b> (Degree or title) <u>L. Richard Webb, M.D.</u>	<b>22b. ADDRESS</b> <u>609 Cherry St, Springfield</u>	<b>22c. DATE SIGNED</b> <u>4-8-60</u>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE</b> <u>3/5/60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Pembina Cemetery</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Christian Co, Mo</u>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>T. B. Chaffin, 2020 1/2 Mo.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>4-12-60</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Effie E. Melton</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 T. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Ozark

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.