

RID DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014850

Dr. Lurie: Registration District No. 128 Primary Registration District No. 2002 Registrar's No. 421 STATE FILE NUMBER

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 52 YRS.	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. JOHN'S HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 223 E. COURT Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last DANIEL THOMAS GORMAN			4. DATE OF DEATH Month Day Year APRIL 12 1960			
---	--	--	--	--	--	--

5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8/12/07	9. AGE (last birthday) 52	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) RETIRED MACHINIST	10b. KIND OF BUSINESS OR INDUSTRY FRISCO R.R.	11. BIRTHPLACE (City and state or country) SPRINGFIELD, MO.	12. CITIZEN OF WHAT COUNTRY USA
---	---	---	---

13a. FATHER'S NAME MICHAEL J. GORMAN	13b. MOTHER'S MAIDEN NAME NORAH HUNTER	14. NAME OF HUSBAND OR WIFE MRS. NORAH HOLDEN
--	--	---

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. 715-10-4448	17. INFORMANT Address MRS. NORAH HOLDEN, 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) Lobar Pneumonia -		INTERVAL BETWEEN ONSET AND DEATH 10 days
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) Epilepsy		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 checked="" type="checkbox"/> NO <input 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 SPRINGFIELD, MO.	COUNTY GREENE	STATE
---	--	--	---	-------------------------	-------

21. I attended the deceased from 4-11-60 to 4-12-60 and last saw ^{her} him alive on 4-12-60	
Death occurred at 9:37 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) Harold H. Lurie, M.D.	22b. ADDRESS 609 Cherry Springfield, Mo.	22c. DATE SIGNED 4-13-60
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4/16/60	23c. NAME OF CEMETERY OR CREMATORY HAZELWOOD	23d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO.
--	-----------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER, SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 4-15-60	26. REGISTRAR'S SIGNATURE Effie B. Melton
--	--	---

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

APR

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 *H. L. Mc Cormac*

Licensed Embalmer No. 27

; 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.