

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-60-014854**

FILED VS MAY 16 1960

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 556

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Greene</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Length of stay in 1b <b>11 Days</b>		c. CITY OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Burge Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1700 S. Delaware</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>KNUTE</b> Middle <b>GUSTAFSON</b> Last <b>GUSTAFSON</b>				4. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>1960</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>18 April 1909</b>		9. AGE (last birthday) <b>51</b>		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) <b>Insurance Agent</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Allstate Insurance</b>		11. BIRTHPLACE (City and state or country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>					
13a. FATHER'S NAME <b>John Gustafson</b>				13b. MOTHER'S MAIDEN NAME <b>Ella (Unknown)</b>				14. NAME OF HUSBAND OR WIFE <b>Lillian Gustafson</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Lillian Gustafson (Wife) Springfield, Mo.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Multiple Contusions Head and Spine</b>										INTERVAL BETWEEN ONSET AND DEATH <b>17 days</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)								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 checked="" 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.) <b>Automobile Accident</b>									
20c. TIME OF INJURY <b>7:45</b>		Hour <b>p.m.</b> Month, Day, Year <b>4/23/60</b>											
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Highway #62</b>		20f. CITY, TOWN, OR LOCATION <b>7 Miles North Rogers,</b>		COUNTY <b>Arkansas</b>		STATE					
21. I attended the deceased from <b>4/28/60</b> to <b>5/9/60</b> and last saw him alive on <b>5/9/60</b> Death occurred at <b>4:15</b> P. m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>Michael J. Telanek M.D.</b>						22b. ADDRESS <b>1636 S. Glenstone Springfield, Missouri</b>			22c. DATE SIGNED <b>5-10-60</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/12/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		23d. LOCATION (City, town, or county) <b>Springfield, Missouri</b>			(State)				
24. FUNERAL DIRECTOR <b>Klingner Mortuary</b>				ADDRESS <b>Springfield, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>5-11-60</b>		26. REGISTRAR'S SIGNATURE <b>Effie S. Mellon</b>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 5 1960

MAY 18 1960

MAY 17 1960

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 Ogle Stone, Jr.  
Licensed Embalmer No. 4176

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.