

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-019010

FILED VS JUN 13 1960

128

Primary Registration District No. 2000 Registrar's No. 5740

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, Mo.</b>		Length of stay in 1b <b>1 week</b>		c. CITY OR TOWN <b>Fair Grove, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" 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>RFD 1, Box 7A</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>CARTER</b> Middle <b>EDGAR</b> Last <b>CLOPTON</b>				4. DATE OF DEATH Month <b>May</b> Day <b>15</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>9/17/78</b>		9. AGE (last birthday) <b>81</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>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (City and state or country) <b>Dadeville, Mo.</b>				12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13a. FATHER'S NAME <b>John Robert Clopton</b>				13b. MOTHER'S MAIDEN NAME <b>Martha Gaunt</b>				14. NAME OF HUSBAND OR WIFE <b>Myrtle Clopton</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Myrtle Clopton, RFD 1, Box 7A, Fair Grove, 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>Coronary occlusion</b>										INTERVAL BETWEEN ONSET AND DEATH <b>sev. days</b>			
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)								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 <b>3:15</b> a.m. p.m. Month, Day, Year <b>5-13-60</b>		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 <b>5-13-60</b> to <b>5-15-60</b> and last saw him alive on <b>5-15-60</b> Death occurred at <b>3:15 a.m.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>DR. HANSS, MD</b>						22b. ADDRESS <b>Springfield, Missouri</b>			22c. DATE SIGNED <b>6/3/60</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/17/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Eastlawn Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>Springfield, Missouri</b>						
24. FUNERAL DIRECTOR <b>Ayre-Goodwin</b>				ADDRESS <b>623 W. Walnut</b>		25. DATE RECD. BY LOCAL REG. <b>6-9-60</b>		26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

JUN 13 1960

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 Robert Wm. Hraw

Licensed Embalmer No. 4732

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.