

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-019038

Dr. Maddux
FILED VS JUN 13 1960 / 28

Primary Registration District No. 2000 Registrar's No. 640

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 lb 68 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) 923 N. GRANT Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ALMA HOWE			4. DATE OF DEATH Month Day Year JUNE 5 1960
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/4/92
9. AGE (last birthday) 68		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) PRACTICAL NURSE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) SPRINGFIELD, MO.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME CHARLES W. WILKERSON	
13b. MOTHER'S MAIDEN NAME ELIZABETH STARK		14. NAME OF HUSBAND OR WIFE CLIFFORD H. HOWE (DEC.)	
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.	17. INFORMANT Address MRS. LEO FRANKEN, 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) Skull Fracture (Basal) DUE TO (b) Fall. DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs
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 checked="" type="checkbox"/> NO <input 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.) Fall down basement stairs.	
20c. TIME OF INJURY 10:00 PM	Hour Month, Day, Year 6-4-60	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) 1151 S. Pickwick		20f. CITY, TOWN, OR LOCATION Springfield	COUNTY STATE Greene Mo.
21. I attended the deceased from 6-4-60 to 6-5-60 and last saw her alive on 6-4-60 Death occurred at 1 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) J.P. Maddux M.D.		22b. ADDRESS Springfield, Mo.	22c. DATE SIGNED 6-6-60
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 6/7/60	23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY	23d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO.
24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 6-7-60	26. REGISTRAR'S SIGNATURE Effie S. Merton

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 17 1967

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 *R/S McCann*

Licensed Embalmer No. 2727

P. O. Address *St. Paul*

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.