

**DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-019049**

**FILED VS JUN 13 1960**  
**ENDED**

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 626A

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>GREENE</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> Length of stay in 1b <u>2 days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DOCTORS' MEMORIAL OSTEOPATHIC</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Polk</u> c. CITY OR TOWN <u>Bolivar</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>415 N. Springfield</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Emma</u> Middle <u>J.</u> Last <u>Law</u>			<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>31</u> Year <u>1960</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>7/21/66</u>	<b>9. AGE</b> (last birthday) <u>94</u>	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HR</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Bolivar, Missouri</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>
<b>13a. FATHER'S NAME</b> <u>S. C. Mitchell</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Martha Hendricks</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Husband Deceased</u>		
<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> <u>no</u>		<b>17. INFORMANT</b> Address <u>  </u>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Collapse 8 hours</u> DUE TO (b) <u>Cerebral hemorrhage 17 hours</u> DUE TO (c) <u>Possible malignancy of GI tract-with metastasis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" 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.) <u>  </u>			
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a.m. <u>  </u> p.m. Month, Day, Year <u>  </u>		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input checked="" type="checkbox"/>				
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE <u>  </u>		<b>20g. CITY, TOWN, OR LOCATION</b> COUNTY STATE <u>  </u>		
<b>21. I attended the deceased from</b> <u>5-29-60 - 11:35 AM</u> to <u>5-31-60 - 3:57 PM</u> and last saw her alive on <u>5-31-60 - 3:58 PM</u> Death occurred at <u>3:57 P.M. three fifty seven P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
<b>22a. SIGNATURE</b> (Degree or title) <u>Andrew Martimick MD</u>			<b>22b. ADDRESS</b> <u>Springfield, Mo</u>		<b>22c. DATE SIGNED</b> <u>5-31-60</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Buried</u>	<b>23b. DATE</b> <u>May 3-60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Greenwood Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Bolivar Mo.</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Pitts Funeral Home - Bolivar, Mo</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>6-7-60</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Effie L. Meeter</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 2 2 WNFJ

**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 Clidney J. Pitts

Licensed Embalmer No. 4939

P. O. Address Bot. Mc

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.