

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-019064

FILED VS JUN 13 1960

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 635

STATE FILE NUMBER

| | | | | | | | | |
|--|--|---|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Greene</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Greene</u> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> | | | Length of stay in 1b | | c. CITY OR TOWN <u>Springfield</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>630 W. Evergreen</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>630 W. Evergreen</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Easter</u> Middle <u>Elsie</u> Last <u>Neff</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1960</u> | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-13-1884</u> | 9. AGE (last birthday) <u>76</u> | 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) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (City and state or country) <u>Pleasant Hope, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U S A</u> | | |
| 13a. FATHER'S NAME <u>Eli Edwards</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Julia Ussery</u> | | | 14. NAME OF HUSBAND OR WIFE <u>deceased</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT Address <u>J. E. Neff, Springfield, Mo.</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> | | | | | | <u>4 weeks</u> | | |
| DUE TO (b) <u>arteriosclerotic Heart Disease.</u> | | | | | | <u>18 months</u> | | |
| DUE TO (c) _____ | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</u> | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown | | |
| 19. WAS AUTOPSY PERFORMED? YES <input 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 | | COUNTY | | STATE | |
| 21. I attended the deceased from <u>12-5-55</u> to <u>6-4-60</u> and last saw her/him alive on <u>5-4-60</u> Death occurred at <u>11:00 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Paul C. Morton, M.D.</u> | | | | 22b. ADDRESS <u>1630 N. Jefferson, Springfield, Mo.</u> | | | 22c. DATE SIGNED <u>6.6.60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>6-6-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Prairie Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>Greene</u> | | (State) <u>Mo.</u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Rex Ramey, Springfield, Mo.</u> | | | 25. DATE RECD. BY LOCAL REG. <u>6-8-60</u> | | 26. REGISTRAR'S SIGNATURE <u>Effie E. Meeter</u> | | | |

DOCUMENT

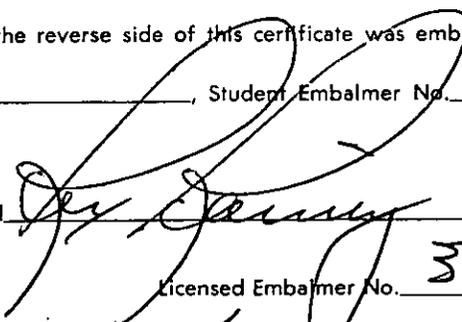
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

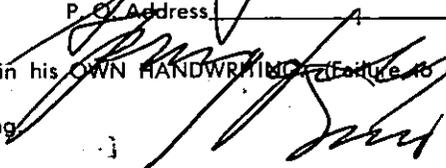
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____, or by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 33

P. O. Address _____


Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING (Article 46 of 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.