

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

Dr. Lurie

=60-022917

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 663

FILED JUN 20 1960

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		c. CITY OR TOWN SPRINGFIELD	
Length of stay in lb		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.		d. STREET ADDRESS (If outside, give location) 1135 N. NATIONAL	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First BARBARA Middle V. Last TOLIVER	4. DATE OF DEATH Month JUNE Day 14 Year 1960
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5. SEX FEMALE	6. COLOR OR RACE NEGROED	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/22/21	9. AGE (last birthday) 39	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER	10b. KIND OF BUSINESS OR INDUSTRY JR. HDGH SCHOOL	11. BIRTHPLACE (City and state or country) CHICAGO, ILL.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME JAMES A. BOND	13b. MOTHER'S MAIDEN NAME ROSEBELL CLECKLEY	14. NAME OF HUSBAND OR WIFE HENRY TOLIVER
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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 MARY TOLIVER, SPRINGFIELD, MO.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus with Infection		INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) " Infection	
	DUE TO (c) Cancer of Breast	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bilateral Adrenalectomy - Jan. 1960		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	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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 SPRINGFIELD	COUNTY GREENE	STATE MO.
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21. I attended the deceased from 6-12-60 to 6-14-60 and last saw her ^{her} alive on 6-12-60
Death occurred at 9 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Harold H. Lurie, M.D. (Degree or title)	22b. ADDRESS 609 Cherry Springfield, Mo.	22c. DATE SIGNED 6-15-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 6/16/60	23c. NAME OF CEMETERY OR CREMATORY ST. PETERSBURG, FLA.	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR'S NAME AND ADDRESS H.H. LUMMEYER FUNERAL HOME SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 6-16-60	26. REGISTRAR'S SIGNATURE Effie B. Melton
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 14 1960

JUN 21 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 _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Gene Johnson

Licensed Embalmer No. 447
P. O. Address Springfield

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