

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-026463

FILED VS. AUG 15 1960 / 28

Registration District No. _____ Primary Registration District No. 2000 Registrar's No. 818B

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 Polk			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Length of stay in 1b 8 Days		c. CITY OR TOWN Brighton		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) RFD#1			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle Jefferson Last Cave				4. DATE OF DEATH Month July Day 29 , Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3 Jan. 1880	9. AGE (last birthday) 80	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) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME P.W. Cave			13b. MOTHER'S MAIDEN NAME Mollie Brazeale			14. NAME OF HUSBAND OR WIFE Maggie Cave	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No <input checked="" type="checkbox"/> No <input type="checkbox"/>			16. SOCIAL SECURITY NO. ?	17. INFORMANT Willard Cave (Son) Springfield, Mo. Address _____			
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) Melaninosis							9 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Probably cerebral metastasis							5 months
DUE TO (c) Carcinoma of base of tongue.							3 years
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"/> N- <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 _____ 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>1958</u> to <u>7/29/60</u> and last saw ^{her} him alive on <u>7/29/60</u> Death occurred at <u>10:42</u> <u>A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Robert B. Stewart, M.D.			22b. ADDRESS 600 S. Glenstone Springfield, Missouri			22c. DATE SIGNED 8-10-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-1-60	23c. NAME OF CEMETERY OR CREMATORY Weaver Cemetery		23d. LOCATION (City, town, or county) Christian County, Mo.		(State)	
24. FUNERAL DIRECTOR Klingner Mortuary Springfield, Mo.			ADDRESS	25. DATE RECD. BY LOCAL REG. 8-12-60	26. REGISTRAR'S SIGNATURE Effie B. Meeton		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

jhc

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 Glen D Williams

Licensed Embalmer No. 4651

P. O. Address Springfield

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.