

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-026486

FILED VS AUG 15 1960

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 830 B

STATE FILE NUMBER

FILED VS AUG 15 1960

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> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b <u>45 years</u>	c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>832 E. Elm</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>ELIZABETH</u> Last <u>GEORGE</u>			4. DATE OF DEATH Month <u>August</u> Day <u>3</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>Feb. 15, 1879</u>	9. AGE (last birthday) <u>81</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>School Teacher</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>	11. BIRTHPLACE (City and state or country) <u>Springfield, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	--	---	--

13a. FATHER'S NAME <u>John F. Lewis</u>	13b. MOTHER'S MAIDEN NAME <u>Annaliza Whittle</u>	14. NAME OF HUSBAND OR WIFE <u>---</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <u>No</u> or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>Mrs. J. D. James</u>	Address
--	---	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary arterial embolism</u> DUE TO (b) <u>arterio-sclerotic vascular disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>unknown</u>
--	--	---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease stated given in PART I (a) <u>congestive heart failure</u>		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 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 <u>Springfield</u>	COUNTY <u>Greene</u>	STATE <u>Mo.</u>
--	--	--	-------------------------	---------------------

21. I attended the deceased from May 30 '60 to Aug 3 '60 and last saw her alive on Aug 3 '60  
Death occurred at 9:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>609 Cherry St.</u>	22c. DATE SIGNED <u>8 Aug 60</u>
--	---------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug 6, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Cemetery</u>	23d. LOCATION (City, town, or county) <u>Berryville, Arkansas</u>
--	---------------------------------	--	--

24. FUNERAL DIRECTOR <u>Jewell E. Windle</u> ADDRESS <u>8 W. Jewell E. Windle, Springfield, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-9-60</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Bernard F. Wright

Licensed Embalmer No. 429

P. O. Address Spring

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