

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-030241**

FILED VS SEP 6 1960  
INDEXED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 895 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo'</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>	Length of stay in 1b <b>50 yrs.</b>	c. CITY OR TOWN <b>Springfield</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Johns</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2027 N Summit</b>
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Amanda</b> Last <b>Herndon</b>			4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept '23-97</b>	9. AGE (last birthday) <b>62</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Seymour Mo'</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>JAMES WALLS</b>		13b. MOTHER'S MAIDEN NAME <b>JANE YINA ENGLAND</b>		14. NAME OF HUSBAND OR WIFE <b>LEONARD HERNDON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>LEONARD HERNDON 2027 N. SUMMIT</b>		

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 <b>15 hours</b>
IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertensive Cardiovascular Disease</b>		
DUE TO (c) <b>Generalized Arteriosclerosis</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Adenocarcinoma of Uterus (Hysterectomy) 8-19-60</b>		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
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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 Month, Day, Year	Hour a.m. p.m.	
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 8-18-60 to 8-25-60 and last saw her <sup>him</sup> alive on 8-24-60.  
Death occurred at 2:52 a m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>H. H. Lurie, M.D.</b>	22b. ADDRESS <b>600 S. Herndon Springfield, Mo</b>	22c. DATE SIGNED <b>8-26-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Aug-29-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield Mo'</b>
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24. FUNERAL DIRECTOR ADDRESS <b>H V Smith 602 N Jefferson St.</b>	25. DATE RECD. BY LOCAL REG. <b>9-2-60</b>	26. REGISTRAR'S SIGNATURE <b>Effie S. Meelton</b>
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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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Herbert V. Smith

Licensed Embalmer No. 4286

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.