

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-030280

FILED VS. AUG 22 1960

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 873

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 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>Midway Hotel</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>J</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1960</u>				
5. SEX <u>Male</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>10-8-1874</u>	9. AGE (last birthday) <u>85</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>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Mt. Vernon, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		
13a. FATHER'S NAME <u>Tom Smith</u>			13b. MOTHER'S MAIDEN NAME <u>Alta Colley</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>499-07-6611</u>		17. INFORMANT <u>Mr. Tom Smith, Springfield, Missouri</u>			
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>Cerebral Vascular Accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Arteriosclerotic Vascular disease</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)						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 Greene Mo.</u>		COUNTY STATE		
21. I attended the deceased from <u>Aug 6, '60</u> to <u>Aug 16 '60</u> and last saw him alive on <u>Aug 16 '60</u> Death occurred at <u>4:55 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Dr. J. L. Colley M.D.</u>				22b. ADDRESS <u>609 Cherry St.</u>		22c. DATE SIGNED <u>17 Aug 60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-18-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Camp Ground Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Lawrence County, Mo.</u>				
24. FUNERAL DIRECTOR <u>Rev. Rainey, Springfield, Missouri</u>			25. DATE RECD. BY LOCAL REG. <u>8-18-60</u>		26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>			

(Licensed Embalmer's Statement on Reverse Side)

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 Lee Mason

Licensed Embalmer No. 4568

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.