

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 11 1960

60-034324

STATE FILE NUMBER

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 190

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dunklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kennett</u>	Length of stay in 1b <u>2 days</u>	c. CITY OR TOWN <u>Campbell</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>Dunklin County Memorial</u> INSTITUTION <u>Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>RFD #3</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOHNIE</u> Middle <u>ABNER</u> Last <u>SPRINGFIELD</u>			4. DATE OF DEATH Month <u>September</u> Day <u>9</u> Year <u>1960</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 31, 1905</u>	9. AGE (last birthday) <u>54</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
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	11. BIRTHPLACE (City and state or country) <u>Alton, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Bill Springfield</u>	13b. MOTHER'S MAIDEN NAME <u>unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Zalpha Mae Springfield</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>	16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT Address <u>Zalpha M. Springfield, Campbell, Mo</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>Cardiovascular Collapse</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>36 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Heat stroke</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) <u>Obesity</u>		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
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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.)
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> / <u> </u> / <u> </u>	

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>Campbell</u>	COUNTY <u>Missouri</u>	STATE <u>Missouri</u>
21. I attended the deceased from <u>9/7/60</u> to <u>9/9/60</u> and last saw ^{him} alive on <u>9/9/60</u> Death occurred at <u>4:20 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Dee or title) <u>R. F. Poluske M.D.</u>	22b. ADDRESS <u>Hammersville, Mo</u>	22c. DATE SIGNED <u>10/5/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 12, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Campbell Missouri</u>

24. FUNERAL DIRECTOR <u>Landess Funeral Home, Campbell, Mo</u>	ADDRESS <u> </u>	25. DATE RECD. BY LOCAL REG. <u>10-6-1960</u>	REGISTRAR'S SIGNATURE <u>Earl H. Hushard</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 25 1961

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VS OCT 11 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 Christine M. Lundeen

Licensed Embalmer No. 4227

P. O. Address Campbell

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