

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034384

FILED VS OCT 3 1960

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 963A

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</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>Unknown</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>423 1/2 S. CAMPBELL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>423 1/2 S. Campbell</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>HOMER</u> Middle <u>H.</u> Last <u>CANTRELL</u>			4. DATE OF DEATH Month <u>September</u> Day <u>17</u> Year <u>1960</u>	
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> <u>Unknown</u>	8. DATE OF BIRTH <u>9/25/1887</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>22</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>	10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (City and state or country) <u>Ash Grove, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Unknown</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>	16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT <u>Springfield, Missouri</u> <u>B. Burk, 423 S. Campbell</u>
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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>Slightly Coronary Occlusion</u> DUE TO (b) <u>Slightly Arteriosclerotic Heart Disease</u> DUE TO (c) <u>UNATTENDED BY A PHYSICIAN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>History of Alcoholism.</u>		

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.) <u></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
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20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <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.) <u></u>	20f. CITY, TOWN, OR LOCATION <u></u>	COUNTY <u></u>	STATE <u></u>
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21. I attended the deceased from Approx. 2:00 A.M. to and last saw her him alive on .
Death occurred at on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE <u>James R. Adams M.D.</u> (Degree or title)	21b. ADDRESS <u>Greene County Health Officer, Spfld Mo</u>	22c. DATE SIGNED <u>9-26-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/24/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hazelwood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>
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24. FUNERAL DIRECTOR <u>Ralph Thieme</u>	ADDRESS <u>1200 Boonville Spfld, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>9-26-60</u>	26. REGISTRAR'S SIGNATURE <u>Offie G. Melton</u>
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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 Ralph H. Ittner

Licensed Embalmer No. 3681

P. O. Address Spring

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.