

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-034435

FILED VS OCT 3 1960

Register District No. 128 Primary Registration District No. 2000 Registrar's No. 971A 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> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Springfield</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>626 West Norton</u>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>John M. Larson</u>			4. DATE OF DEATH Month Day Year <u>Sept. 20 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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-26-1878</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Marine Captain</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>	11. BIRTHPLACE (City and state or country) <u>Norway</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
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13a. FATHER'S NAME <u>Olai Larson</u>	13b. MOTHER'S MAIDEN NAME <u>unknown</u>	14. NAME OF HUSBAND OR WIFE <u>deceased</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>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT Address <u>Mrs. Robert Ashcroft, Springfield, Mo.</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>Carcinoma of bladder with metastases</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1955</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	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	
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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.) <u>-</u>
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20c. TIME OF INJURY Hour a.m. p.m. <u>-</u>	Month, Day, Year <u>-</u>
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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 COUNTY STATE
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21. I attended the deceased from 26 Jun 60 to 7 20-60 and last saw <sup>her</sup>him alive on 20 Sept 60  
Death occurred at 10:00 h. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Effie M. Secord M.D.</u>	22b. ADDRESS <u>Professional Bldg</u>	22c. DATE SIGNED <u>26 Sept 60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9-21-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chicago Illinois</u>	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR ADDRESS <u>Rex Rainey, Springfield, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-27-60</u>	26. REGISTRAR'S SIGNATURE <u>Effie M. Secord</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 25 1961

OCT 4 1960

OCT 25 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 \_\_\_\_\_ 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 comply 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.