

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034445

LED VS OCT 17 1960

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1014 C

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>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>1 DAY</u>	c. CITY OR TOWN <u>SPRINGFIELD</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BURGE HOSP'</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route 2</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Angie</u> Middle <u>H.</u> Last <u>MELTON</u>			4. DATE OF DEATH Month <u>OCT</u> Day <u>5</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>9-15-1913</u>	9. AGE (last birthday) <u>47</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>WIVE STOCK DEALER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRUCKING</u>		11. BIRTHPLACE (City and state or country) <u>Greene Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>JOHN MELTON</u>		13b. MOTHER'S MAIDEN NAME <u>COSEY HANKINS</u>		14. NAME OF HUSBAND OR WIFE <u>NEWBIE</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>493-16-6923</u>		17. INFORMANT <u>Nellie Melton</u> Address <u>SPRINGFIELD</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) Coronary Occlusion, acute

CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO (b) with myocardial infarction 1 day

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.
 Yes No 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>Oct 4</u> to <u>Oct 5</u> and last saw ^{her} him alive on <u>Oct 4, 1960</u>	COUNTY _____ STATE _____
21. I attended the deceased from _____ to _____ and last saw ^{her} him alive on <u>Oct 4, 1960</u> Death occurred at <u>5:30 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>Don J. Silsby M.D.</u>	22b. ADDRESS <u>Springfield, Mo</u>	22c. DATE SIGNED <u>10-11-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10-8-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DANFORTH</u>
24. FUNERAL DIRECTOR <u>Robert Bergman</u> ADDRESS <u>Dayton, Mo</u>		23d. LOCATION (City, town, or county) (State) <u>Greene Co. Mo.</u>

25. DATE RECD. BY LOCAL REG. <u>10-13-60</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Meeter</u>
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

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 Max L Miller

Licensed Embalmer No. 4720

P. O. Address Mansfield

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.