

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 14 1960

-60-037985

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1115 STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		c. CITY OR TOWN SPRINGFIELD	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2221 N. National		d. STREET ADDRESS (If outside, give location) 1700 E. Pythian	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
BESS	AMY	ALLEN	November	4	1960

5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4 Feb. 1895	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
-------------------------	----------------------------------	---	--	-------------------------------------	---------------------------	------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY USA
---	--	---	---

13a. FATHER'S NAME Jess Bockman	13b. MOTHER'S MAIDEN NAME Elizabeth Kelly	14. NAME OF HUSBAND OR WIFE Leonard Allen
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. No	17. INFORMANT Leonard Allen (Husband) Springfield, Mo.	Address
--	--------------------------------------	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 3 months
IMMEDIATE CAUSE (a) Metastatic Carcinoma Pelvic Organs		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Carcinoma Cervix Uteri (6-7-1960)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Surgery 6-14-60 in factory laboratory - Inoperable Carcinoma		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	COUNTY	STATE
--	--	------------------------------	--------	-------

21. I attended the deceased from June 7, 1960 to 11/4/60 and last saw her him alive on _____
Death occurred at 3:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE J. N. Wakeman, M.D.	(Degree or title)	22b. ADDRESS 600 S. Glenstone Springfield, Missouri	22c. DATE SIGNED 11-7-60
---	-------------------	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/7/60	23c. NAME OF CEMETERY OR CREMATORY White Chapel	23d. LOCATION (City, town, or county) Springfield, Missouri
--	-----------------------------	---	---

24. FUNERAL DIRECTOR KLINGNER MORTUARY, INC. SPRINGFIELD MO.	ADDRESS 11-9-60	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE Effie B. Nelson
--	---------------------------	------------------------------	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

jhc

JAN 2 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Max Fla

Licensed Embalmer No. _____

P. O. Address **SPRINGFIELD**

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