MO DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 14 1960

-60-038009
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1129

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY: GREENE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: SPRINGFIELD
Length of stay in 1b:
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BURGE HOSPITAL
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived? If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: GREENE
c. CITY OR TOWN: SPRINGFIELD
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 1313 NICHOLS
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First NELLIE Middle MAUDE Last CHAPPELL

4. DATE OF DEATH: Month NOV. Day 8, Year 1960

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 21 OCT. 1892
9. AGE (last birthday): 68
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): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (City and state or country): ILLINOIS
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: UNKNOWN
13b. MOTHER'S MAIDEN NAME: UNKNOWN
14. NAME OF HUSBAND OR WIFE: WIDOWED

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 499-22-4657
17. INFORMANT: RUELL CHAPPELL (SON) Address: SPGFD. MO.

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
IMMEDIATE CAUSE (a)	Cerebral Vascular Hemorrhage	6 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Multiple Myeloma	1 1/2 years
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 ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 6-20-59, to 11-8-60 and last saw her alive on 11-8-60
Death occurred at 1:35 P.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Robert C. Swanson M.D.
22b. ADDRESS: 1715 BOONVILLE SPRINGFIELD, MO.
22c. DATE SIGNED: 11-8-60

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 11-10-60
23c. NAME OF CEMETERY OR CREMATORY: WHITE CHAPEL
23d. LOCATION (City, town, or county) (State): SPRINGFIELD, MO.

24. FUNERAL DIRECTOR: Klingners
ADDRESS: Springfield, Mo.
25. DATE RECD. BY LOCAL REG.: 11-9-60
26. REGISTRAR'S SIGNATURE: Effie G. Melton

(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 b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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