IRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 14 1960

-60-038096
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1125

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): 2136 N. Grant
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: James Middle: Arthur Last: Twigger
4. DATE OF DEATH: Month: November Day: 7 Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 4 June 1887
9. AGE (last birthday): 73
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): Broom Maker
10b. KIND OF BUSINESS OR INDUSTRY: Broom Maker
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Maude Twigger
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.: Unknown
17. INFORMANT: Maude Twigger (Wife) Address: Springfield, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 4-5 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Cardiovascular Disease — UNKNOWN
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 ☒
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 5:00 pm 11-7-60, to 11/7/60 and last saw him alive on 11-7-60
Death occurred at 8:10 P.m on the date stated above, and to the best of my knowledge, from the causes stated.

BY AFFIDAVIT OF

22a. SIGNATURE (Degree or title): Don E Mendotti, M.D.
22b. ADDRESS: 1630 N. Jefferson Springfield, Missouri
22c. DATE SIGNED: 11-8-60
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 11/9/60
23c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery
23d. LOCATION (City, town, or county) (State): Springfield, Missouri
24. FUNERAL DIRECTOR: KLINGNER MORTUARY, INC. ADDRESS: SPRINGFIELD MO.
25. DATE RECD. BY LOCAL REG.: 11-10-60
26. REGISTRAR'S SIGNATURE: Effie B. Mellon

jhc

(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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. _____

P. O. Address SPRINGFIELD

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