

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041637

FILED NOV 28 1960

STATE FILE NUMBER

INDEXED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1181

| | | | | | | | | |
|--|--|---|---|---|--|--|---|-------|
| 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> | | Length of stay in 1b <u>17 yrs.</u> | | c. CITY OR TOWN <u>Springfield</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hendley Hospital</u> | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>1135 E. Atlantic</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>H.</u> Last <u>Fredrick</u> | | | | 4. DATE OF DEATH Month <u>November</u> Day <u>23</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>5-6-1879</u> | 9. AGE (last birthday) <u>81</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>Farmer & Grocery</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm & Store</u> | | 11. BIRTHPLACE (City and state or country) <u>Illinois</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>Lee Fredrick</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Ananda Gore</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Sarah Fredrick</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u> | | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT Address <u>Mrs. Sarah Fredrick, Springfield, Mo.</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) <u>Cerebral Vascular accident</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> | |
| 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 | | |
| 19. WAS AUTOPSY PERFORMED? YES <input 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.) | | | | |
| 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 <u>Nov 17, 60</u> to <u>Nov 23, 60</u> and last saw him alive on <u>Nov 23, 60</u> Death occurred at <u>1:00 hr</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Carle V. Schroy, M.D.</u> | | | | 22b. ADDRESS <u>1630 N. Jefferson, Springfield</u> | | | 22c. DATE SIGNED <u>11/25/60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>11-25-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>East Lawn Cemetery</u> | | 23d. LOCATION (City, town, or county) Mo. (State) <u>Springfield, Missouri</u> | | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Rex Rainey, Springfield, Mo.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>11-25-60</u> | | 26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 29 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. 456

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.