

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041653

FILED VS DEC 1 2 1960

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1205 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>Missouri</u> b. COUNTY <u>Webster</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Fordland</u>	
Length of stay in 1b <u>33 Days</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>DRS' MEMORIAL HOSPITAL</u>		d. STREET ADDRESS (If outside, give location)	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>EFFIE</u> Middle <u>JOHN</u> Last <u>JOHN</u>			4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Female</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>7-16-1889</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fordland, Missouri</u>		11. BIRTHPLACE (City and state or country) <u>United States</u>		
13a. FATHER'S NAME <u>E. Burke</u>		13b. MOTHER'S MAIDEN NAME <u>Susan (unknown)</u>		14. NAME OF HUSBAND OR WIFE <u>Lester John</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>-----</u>		17. INFORMANT <u>[Signature]</u> Address <u>[Signature]</u>		

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) <u>Respiratory failure</u>				<u>3 Days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Pneumonia</u>			<u>5 Days</u>
	DUE TO (c) <u>Pulmonary Embolus</u>		<u>7 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fractured left hip & Diabetes Melitus & Cardiac Decompensation</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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 Month, Day, Year a.m. p.m.			
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 10-31-60 to 12-2-60 and last saw her him alive on 12-2-60
Death occurred at 5:35 P a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deedee or title) <u>Andrew Martinick, D.O.</u>		22b. ADDRESS <u>700 E. Sunshine Springfield, Mo</u>		22c. DATE SIGNED <u>12-2-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12-4-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FORDLAND Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>WEBSTER Co. MO-</u>
24. FUNERAL DIRECTOR ADDRESS <u>Robert Bergman Dayman, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-6-60</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 E Miller

Licensed Embalmer No. 4720

P. O. Address Manassas

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