

# R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041718

FILED VS DEC 5 1960/28

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 1196 STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Greene</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>North Campbell Towns.</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>O'Hara Road</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Greene</u> c. CITY OR TOWN <u>North Campbell Township</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>O'Hara Road</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <u>Robert</u> Middle _____ Last <u>Smith</u>			<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>	9. AGE (last birthday) <u>75</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>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (City and state or country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
13a. FATHER'S NAME <u>unknown</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>unknown</u>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>	16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT Address <u>Mrs. Orville Smith, Springfield, Mo.</u>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lately Myocardial insufficiency</u> DUE TO (b) <u>Generalized arteriosclerosis,</u> DUE TO (c) <u>Especially Cerebral and Coronary</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <p style="text-align: center; font-weight: bold; font-size: 1.2em;">UNATTENDED BY A PHYSICIAN</p>		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 _____ 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 \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at 5:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>James R. Amos, M.D. Health Officer - Spfld Mo</u>		22b. ADDRESS <u>Greene Co. Health Dept Spfld Mo</u>		22c. DATE SIGNED <u>12-2-60</u>	
23b. DATE <u>12-3-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hazelwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Springfield Missouri</u>	
24. FUNERAL DIRECTOR <u>Rex Rainey, Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-2-60</u>		26. REGISTRAR'S SIGNATURE <u>Effie G. 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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Lee Mason

Licensed Embalmer No. 4256  
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.