

# IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 19 1960

-60-045791

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. \_\_\_\_\_ Registrar's No. 1241

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Greene</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural 2nd Franklin</b>		Length of stay in 1b	c. CITY OR TOWN <b>Rural 2nd Franklin</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Springfield RFD#1</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Springfield RFD#1</b>	Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print) First <b>Alice</b> Middle <b>E.</b> Last <b>Israel</b>			<b>4. DATE OF DEATH</b> Month <b>December</b> Day <b>12.</b> Year <b>1960</b>		
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<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>18 Nov. 1881</b>	<b>9. AGE (last birthday)</b> <b>79</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Missouri</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>
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<b>13a. FATHER'S NAME</b> <b>James Dysart</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Alexander</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Deceased</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	<b>16. SOCIAL SECURITY NO.</b> <b>No</b>	<b>17. INFORMANT</b> Address <b>RFD#1</b> <b>Dwight Israel (Son) Springfield, Mo.</b>
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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) <b>Arterio - Sclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____ 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.	Month, Day, Year		
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	COUNTY	STATE
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21. I attended the deceased from 7-11-55 to 12/12/60 and last saw her <sup>her</sup> <sub>him</sub> alive on 11-28-60  
 Death occurred at 5:30 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> <i>[Signature]</i> (Degree/Title) <i>MD</i>	<b>22b. ADDRESS</b> <b>1715 Boonville Springfield, Missouri</b>	<b>22c. DATE SIGNED</b> <b>12-12-60</b>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE</b> <b>12-14-60</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Comfort Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>Greene County, Missouri</b>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>KLINGNER MORTUARY, INC. SPRINGFIELD MO.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>12-15-60</u>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Effie S. Melton</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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**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 John B. Klingner

Licensed Embalmer No. 510

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.