

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-000985

FILED VS. FEB. 6 1961

128

Primary Registration District No. 2000

Registrar's No. 111

STATE FILE NUMBER

AMENDED

1. PLACE OF DEATH a. COUNTY <u>G. Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Wright</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b <u>3 Hours</u>		c. CITY OR TOWN <u>HARTVILLE</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOHNS HOSPITAL</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>STAR ROUTE</u>		Reside on Farm Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>EARL</u> Last <u>LUNSFORD</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>28</u> Year <u>1961</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>9-27-1897</u>		9. AGE (last birthday) <u>73</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>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>CAIRO, ILL.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ALBERT LUNSFORD</u>				13b. MOTHER'S MAIDEN NAME <u>EVA MUELLER</u>		14. NAME OF HUSBAND OR WIFE <u>GRACE LUNSFORD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>I - 1917</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>ST. JOHNS HOSPITAL, 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>Myocardial infarction</u> DUE TO (b) <u>Coronary occlusion</u> DUE TO (c) <u>Arteriosclerotic Vascular disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>1) Hypertension chronic. 2) Aneurysm of aorta</u> 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								INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>8 hours</u> <u>Unknown</u>	
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 _____ 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.) <u>Springfield Greene, Mo</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Oct 26 1955</u> to <u>Jan 8 61</u> and last saw him alive on <u>Feb 3, 1960</u> Death occurred at _____ <u>2 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>[Signature]</u> (Degree or title)						22b. ADDRESS <u>609 Cherry St</u>		22c. DATE SIGNED <u>Jan 16 1961</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>1-31-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LITTLE CREEK</u>		23d. LOCATION (City, town, or county) (State) <u>Wright County, Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Carlos Blaha, Hartsville, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>2-1-61</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

MAR 17 1961

MAR 20 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Max L Miller

Licensed Embalmer No. 4720

P. O. Address Manfield Mo.

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.