

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-001030

Dr. Clawson

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 135

STATE FILE NUMBER

AMENDED

FILED VS FEB 14 1961

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		c. CITY OR TOWN SPRINGFIELD	
Length of stay in 1b YRS.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.		d. STREET ADDRESS (If outside, give location) 2334 W. OLIVE	
3. NAME OF DECEASED (Type or print) First Middle Last BARBARA JOAN SMITH		4. DATE OF DEATH Month Day Year FEB. 4 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/28/28
9. AGE (last birthday) 32		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ROCKFORD, ILL.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME LEE TRILBY	
13b. MOTHER'S MAIDEN NAME MINNIE SMITH		14. NAME OF HUSBAND OR WIFE HAROLD SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT HAROLD SMITH,		Address SPRINGFIELD, MO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Parasectic necrosis - DUE TO (b) Acute hemorrhagic Parasectic DUE TO (c) 9 days Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) gall bladder none in common duct cholelithiasis - in common duct			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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"/>	20b. SUICIDE <input type="checkbox"/>	20c. 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 29 January 61 to 4 Jan 61 and last saw her/him alive on 3 Jan 61 Death occurred at 5:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J. W. Clawson M.D.		22b. ADDRESS 609 Cherry Springfield, Mo 65801	
22c. DATE SIGNED 6 Feb 61			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 2/7/61	23c. NAME OF CEMETERY OR CREMATORY MAPLE PARK	23d. LOCATION (City, town, or county) (State) AURORA, MISSOURI
24. FUNERAL DIRECTOR H.H. LOHMEYER FUNERAL HOME		25. DATE RECD. BY LOCAL REG. 2-7-61	
ADDRESS SPRINGFIELD, MO.		26. REGISTRAR'S SIGNATURE Effie B. Melton	

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

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 *[Handwritten Signature]*

Licensed Embalmer No. 2727

P. O. Address *[Handwritten Address]*

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.