

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-013319**

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 477

AMENDED

**FILED MAY 15 1961**

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Polk</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Length of stay in 1b <b>4 weeks</b>	c. CITY OR TOWN <b>Morrisville</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Burge Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>no street address</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JESS</b> Middle <b>C.</b> Last <b>DEGRAFFENREID</b>			4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1886</b>	9. AGE (last birthday) <b>75</b>	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) <b>Groceryman, Packing Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Meat Grocery, Packing Co.</b>		11. BIRTHPLACE (City and state or country) <b>Polk Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Joe Degraffenreid</b>		13b. MOTHER'S MAIDEN NAME <b>Martha Griffin</b>		14. NAME OF HUSBAND OR WIFE <b>Ina Degraffenreid</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Millard Degraffenreid, Springfield, Mo.</b> Address <b>Route 5</b>		

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) <b>Congestive Heart Failure</b>		<b>SEV. weeks</b>
DUE TO (b) <b>Coronary occlusion</b>		<b>SEV. weeks</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) <b>Branchial Cystoma - Wernia.</b>		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 _____ 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.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from 1:9 50 to May 11, 1961 and last saw him alive on May 11, 1961  
Death occurred at 9:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>	(Degree or title) <b>M. D.</b>	22b. ADDRESS <b>Springfield, Mo.</b>	22c. DATE SIGNED <b>5-12-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 13, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Morrisville Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Morrisville, Missouri</b>
24. FUNERAL DIRECTOR <b>Jewell E. Windle</b> ADDRESS <b>R.W.</b>	25. DATE RECD. BY LOCAL REG. <b>5-12-61</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

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 Bernard F. Wright

Licensed Embalmer No. 4293

P. O. Address Springfield

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.