

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-013420

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 249

STATE FILE NUMBER

AMENDED

FILED APR 17 1961

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Greene</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		a. STATE <b>Mo.</b>		b. COUNTY <b>Greene</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Johns Hospital</b>		Length of stay in 1b <b>33 years</b>		c. CITY OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <b>942 W. Linwood</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JACK HOLLIS ROURKE</b>				4. DATE OF DEATH Month Day Year <b>April 8 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>11/29/1927</b>	9. AGE (last birthday) <b>33</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>9</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>	
10a. OCCUPATION (If of work done during most of working life, or if retired) <b>C.O. Power Plant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>James River Plant Springfield, Mo.</b>		11. BIRTHPLACE (City and state or country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Hollie Rourke</b>			13b. MOTHER'S MAIDEN NAME <b>Amy Schaver</b>		14. NAME OF HUSBAND OR WIFE <b>Lorraine Rourke</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW 2 Navy</b>			17. INFORMANT <b>942 W. Linwood, Springfield, Mo.</b> <b>Mrs. Lorraine Rourke, Missouri</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sub Aneurysmal Hemorrhage</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>14 hr</b>	
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		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <b>4-8-61</b> to <b>4-8-61</b> and last saw him alive on <b>4-8-61</b> Death occurred at <b>6:45 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree of title) <b>[Signature] MD</b>				22b. ADDRESS <b>1715 Boonville Springfield Mo</b>		22c. DATE SIGNED <b>4-10-61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4/11/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Weaver Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Christian Co. Missouri</b>		
24. FUNERAL DIRECTOR <b>Ralph Thieme, Springfield, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>4-11-61</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

HEMORRHOID SHOULD READ

APR 18 1961

APR 19 1961

**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 Keith Collier

Licensed Embalmer No. 3632

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.