

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-61-017068**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DR. **ASHLEY**

Registration District No. **128**

Primary Registration District No. **2000**

Registrar's No. **496C**

STATE FILE NUMBER

AMENDED

**FILED MAY 29 1961**

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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>GREENE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Length of stay in 1b <b>17 YRS.</b>	c. CITY OR TOWN <b>SPRINGFIELD</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>BAPTIST HOSP.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>505 S. MARKET</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPHINE CROSS</b>			4. DATE OF DEATH Month Day Year <b>MAY 16 1961</b>
5. SEX <b>FEMALE</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>9/20/20</b>
9. AGE (last birthday) <b>40</b>		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) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BILLINGS, 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>KARL KASTENDIECK</b>	13b. MOTHER'S MAIDEN NAME <b>MINNIE PEITER</b>
14. NAME OF HUSBAND OR WIFE <b>JAMES L. CROSS</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO.
17. INFORMANT <b>JAMES L. CROSS, SPRINGFIELD, MO.</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>Abdominal Carcinomatosis</b> DUE TO (b) <b>primary site undetermined</b> DUE TO (c) 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) 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"/> 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 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 <b>Dec 1960</b> to <b>5-16-61</b> and last saw him alive on <b>5-16-61</b> Death occurred at <b>12:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <b>A. Ashley MD</b>		22b. ADDRESS <b>Springfield Mo</b>	22c. DATE SIGNED <b>5-19-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>5/19/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. PETER'S CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>BILLINGS, MO.</b>
24. FUNERAL DIRECTOR ADDRESS <b>H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>5-22-61</b>	26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>

**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 W. H. V. M. C. O'Connell

Licensed Embalmer No. 2729

P. O. Address W. H. V. M. C. O'Connell

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.