SOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-61-024769
STATE FILE NUMBER

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 720A

FILED AUG 14 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Springfield Mo. — Length of stay in 1b: 5days
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Baptist Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo — b. COUNTY: Dade
c. CITY OR TOWN: Lockwood Mo — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): West 5th — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Ola — Middle: — Last: Fortner
4. DATE OF DEATH: Month: July — Day: 29 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: Sept 28 1885
9. AGE (last birthday): 75 — IF UNDER 1 YEAR: Months 10, Days 1 — IF UNDER 24 HR: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (City and state or country): Lawrence Co Mo
12. CITIZEN OF WHAT COUNTRY: usa
13a. FATHER'S NAME: William Hood
13b. MOTHER'S MAIDEN NAME: Susan Hood
14. NAME OF HUSBAND OR WIFE: Joy Fortner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
17. INFORMANT: Joy Fortner — Address: Lockwood Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Dis — 2 yrs.
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Cholecystectomy 7-25-61
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 7-24-61, to 7-29-61 and last saw her/him alive on 7-29-61
Death occurred at 10:10 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] — 22b. ADDRESS: Springfield Mo — 22c. DATE SIGNED: 8-1-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Aug 1 1961
23c. NAME OF CEMETERY OR CREMATORY: Shiloh
23d. LOCATION (City, town, or county) (State): Lawrence Co Mo. Dade

24. FUNERAL DIRECTOR — ADDRESS: Allison Funeral Home Greenfield Mo.
25. DATE RECD. BY LOCAL REG.: 8-7-61
26. REGISTRAR'S SIGNATURE: Effie G. Melton

(Licensed Embalmer's Statement on Reverse Side)

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. R. Allison

Licensed Embalmer No. 4404

P. O. Address Greenfield

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.