

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-028144

AMENDED FILED JUL 18 1961 Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 102

STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | | |
|--|---|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Vernon | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Greene | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Township | | Length of stay in 1b 3yrs. | c. CITY OR TOWN Springfield | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Hosp. # 3 | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) R # 4, Box 558 | | |
| 3. NAME OF DECEASED (Type or print) First Dorothy Middle Lorene Last Ginn | | | 4. DATE OF DEATH Month June Day 29 Year 1961 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 2-12-15 | 9. AGE (last birthday) 46 | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (City and state or country) Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S. | |
| 13a. FATHER'S NAME Edward J. Ginn | | 13b. MOTHER'S MAIDEN NAME Lucy Ann Kilingsmith | | 14. NAME OF HUSBAND OR WIFE Never married | | |
| 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. None | 17. INFORMANT Address State Hospital # 3, Nevada, 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) Broncho Pneumonia | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary Vessel Disease | | | | | Years | |
| DUE TO (c) | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) (Mongoloid Idiot). | | | | 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 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 2-27-58 to 6-29-61 and last saw her ^{her} alive on 6-29-61 Death occurred at 3:03 p. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | |
| 22a. SIGNATURE (Degree or title) <i>E. Allen Pickens MD</i> | | | 22b. ADDRESS State Hosp. # 3, Nevada, Mo. | | 22c. DATE SIGNED 6-29-61 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 6/30/61 | 23c. NAME OF CEMETERY OR CREMATORY Clear Creek Cemetery | | 23d. LOCATION (City, town, or county) (State) Springfield, Missouri | | |
| 24. FUNERAL DIRECTOR Klingner Funeral Home | | ADDRESS Springfield, Missouri | 25. DATE RECD. BY LOCAL REG. July 10-1961 | 26. REGISTRAR'S SIGNATURE <i>Anna L. Ferry</i> | | |

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 *Percy F. Webster*
Licensed Embalmer No. 4805
P. O. Address Neenah, Wis.

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.