

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-031637

STATE FILE NUMBER

AMENDED

Registration District No. 360  
FILED AUG 29 1961

Primary Registration District No. 6225 Registrar's No. 135

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|                                                                                                                                                                |                               |                                                                                                                                                                      |                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Vernon</b>                                                                                                                   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>Greene</b>                                 |                                    |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Nevada - Washington twsp</b>                                                           |                               | c. CITY OR TOWN <b>Springfield</b>                                                                                                                                   |                                    |
| Length of stay in 1b <b>2 yrs</b>                                                                                                                              |                               | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                    |                                    |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Nevada State Hospital</b>                                                    |                               | d. STREET ADDRESS (If outside, give location) <b>703 South Glenstone</b>                                                                                             |                                    |
| Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                             |                               |                                                                                                                                                                      |                                    |
| 3. NAME OF DECEASED<br>(Type or print) First <b>Enola</b> Middle <b>-</b> Last <b>Handley</b>                                                                  |                               | 4. DATE OF DEATH Month <b>Aug.</b> Day <b>21,</b> Year <b>1961</b>                                                                                                   |                                    |
| 5. SEX <b>female</b>                                                                                                                                           | 6. COLOR OR RACE <b>white</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>          | 8. DATE OF BIRTH <b>10/17/1881</b> |
| 9. AGE (last birthday) <b>79</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>Massachusetts</b>                                                                                                               |                                    |
| 11. BIRTHPLACE (City and state or country) <b>U.S.</b>                                                                                                         |                               | 12. CITIZEN OF WHAT COUNTRY                                                                                                                                          |                                    |
| 13a. FATHER'S NAME <b>F. N. Calvin</b>                                                                                                                         |                               | 13b. MOTHER'S MAIDEN NAME <b>Julia Bovee</b>                                                                                                                         |                                    |
| 14. NAME OF HUSBAND OR WIFE <b>Dr. W. E. Handley</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. <b>unknown</b>                                                                                                                               |                                    |
| 17. INFORMANT <b>Hospital Records.</b>                                                                                                                         |                               | Address                                                                                                                                                              |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary vessel disease</b> |                               | INTERVAL BETWEEN ONSET AND DEATH <b>years</b>                                                                                                                        |                                    |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Atherosclerosis</b>                                |                               | <b>years</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)                              |                               | PART III. If deceased was female was there a pregnancy in last 90 days.<br><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 <b>1:45 p.m.</b> Month, Day, Year <b>June 21, '59</b>                                                                                 |                               |                                                                                                                                                                      |                                    |
| 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 <b>Springfield, Missouri</b>                                                                                                      |                               | COUNTY <b>Greene</b> STATE <b>Mo.</b>                                                                                                                                |                                    |
| 21. I attended the deceased from <b>June 21, '59</b> to <b>Aug. 21, 1961</b> and last saw her alive on <b>Aug. 21, 1961</b>                                    |                               | Death occurred at <b>1:45 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.                                                |                                    |
| 22a. SIGNATURE (Degree or title) <b>E. Allen Pickens M.D.</b>                                                                                                  |                               | 22b. ADDRESS <b>State Hospital, Nevada, Mo.</b>                                                                                                                      |                                    |
| 22c. DATE SIGNED <b>8/21/61</b>                                                                                                                                |                               |                                                                                                                                                                      |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>                                                                                                       |                               | 23b. DATE <b>8/21/61</b>                                                                                                                                             |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Maple Park Cemetery</b>                                                                                                  |                               | 23d. LOCATION (City, town, or county) <b>Springfield, Missouri</b>                                                                                                   |                                    |
| 24. FUNERAL DIRECTOR <b>Jewell E. Windle, Springfield, Mo.</b>                                                                                                 |                               | 25. DATE REC'D. BY LOCAL REG. <b>8-25-1961</b>                                                                                                                       |                                    |
| 26. REGISTRAR'S SIGNATURE <b>Anna E. Jerry</b>                                                                                                                 |                               |                                                                                                                                                                      |                                    |

(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

*Percy F. Milster*

Licensed Embalmer No. 4805

P. O. Address Nevada, Mo.

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.