

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032523

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 916

1. PLACE OF DEATH a. COUNTY Greene		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 Springfield		Length of stay in 1b 47 years	c. CITY OR TOWN Springfield Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge-Protestant		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2012 N. National Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First BEULAH Middle GRACE Last KINGADE	4. DATE OF DEATH Month September Day 27 Year 1961
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/22/1889	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min. 0	IF UNDER 24 HR Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Imogene, Iowa	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Samuel Daykin	13b. MOTHER'S MAIDEN NAME Mary Hown	14. NAME OF HUSBAND OR WIFE John (deceased)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. No	17. INFORMANT 1256 S. Florence Ivan Kincade, Springfield, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	ADENOCARCINOMA of Lt. Colon	Months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) post. Op. pulmonary Embolus	1 hr.
	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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour 5:00 a.m. 5:00 p.m.	Month, Day, Year
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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 Springfield, Mo.	COUNTY	STATE
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21. I attended the deceased from 9-13-61 to 9-27-61 and last saw her alive on 9-26-61
Death occurred at 5:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Joseph N. Hills M.D. (Degree or title)	22b. ADDRESS Springfield, Mo.	22c. DATE SIGNED 9-28-61
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	23b. DATE 9/29/1961	23c. NAME OF CEMETERY OR CREMATORY East Lawn Cemetery	23d. LOCATION (City, town, or county) (State) Springfield, Mo.
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24. FUNERAL DIRECTOR Ralph Thieme	1200 ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 9-29-61	26. REGISTRAR'S SIGNATURE Effie E. Meeter
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DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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 Collins

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.