

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036554

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 994

STATE FILE NUMBER

AMENDED FILED OCT 30 1961

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</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	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>Burge Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1136 W. Hamilton</b>	
3. NAME OF DECEASED (Type or print) First <b>JOE</b> Middle <b>W.</b> Last <b>FALLIN</b>			4. DATE OF DEATH Month <b>October</b> Day <b>18</b> , Year <b>1961</b>		
5. SEX <b>Male</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>13 Nov. 1887</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furniture Mg. Co. Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (City and state or country) <b>Arkansas</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>H.L. Fallin</b>		13b. MOTHER'S MAIDEN NAME <b>Rachel Jones</b>		14. NAME OF HUSBAND OR WIFE <b>Christie Fallin</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>No</b>	17. INFORMANT Address <b>1136 Hamilton</b> <b>Christie Fallin (Wife) 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>Coronary occlusion</b>					INTERVAL BETWEEN ONSET AND DEATH <b>sev. hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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. <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 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 <b>10-1-61</b> to <b>10/18/61</b> and last saw him alive on <b>10/18/61</b>			Death occurred at <b>3:30</b> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <i>W. H. H. H.</i> (Degree or title) <b>W. H. H.</b>		22b. ADDRESS <b>600 S. Glenstone</b> <b>SPRINGFIELD MO.</b>		22c. DATE SIGNED <b>10-20-61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-21-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Comfort Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Greene County, Missouri</b>		
24. FUNERAL DIRECTOR <b>KLINGNER MORTUARY, INC. SPRINGFIELD MO.</b> jhc		25. DATE RECD. BY LOCAL REG. <b>10-24-61</b>	26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i>		

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTANT OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

Klingner Mortuary, Inc.  
Benton & Pacific  
SPRINGFIELD 2, MO.

**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 *Ogle Stone Jr.*

Licensed Embalmer No. 14176

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.