

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040727

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1197

AMENDED

FILED DEC 17 1961

1. PLACE OF DEATH a. COUNTY <b>Greene</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</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>Strafford</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Handley Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Route # 2</b>		
3. NAME OF DECEASED (Type or print) First <b>AMANDA</b> Middle <b>JANE</b> Last <b>HOSKINS</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>4,</b> Year <b>1961</b>			
5. SEX <b>Female</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>7/10/1883</b>	9. AGE (last birthday) <b>78</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>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaking</b>		11. BIRTHPLACE (City and state or country) <b>Morgan Co. Missouri</b>		
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Charles Cooper</b>		13b. MOTHER'S MAIDEN NAME <b>Rebecca Bailey</b>		
14. NAME OF HUSBAND OR WIFE <b>Samuel</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>-----</b>		
17. INFORMANT <b>Oshkosh, Wisconsin.</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>Acute pulmonary edema</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		
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 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 <b>11-26-61</b> to <b>12-4-61</b> and last saw her alive on <b>12-4-61</b> Death occurred at <b>9:50</b> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>Carle H. Schragg M.D.</b> (Degree or title)			22b. ADDRESS <b>1630 N. Jefferson, Springfield, Mo.</b>		22c. DATE SIGNED <b>12-7-61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/7/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Liberty Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Greene County, Missouri.</b>		
24. FUNERAL DIRECTOR <b>Springfield, Missouri.</b> <b>Ralph Thieme, 1200 Boonville Ave.</b>			25. DATE RECD. BY LOCAL REG. <b>12-7-61</b>	26. REGISTRAR'S SIGNATURE <b>Effie E. Mellon</b>		

DATE AWIENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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

*Richard L. Strawn*

Licensed Embalmer No. 5164

P. O. Address Appt, Ill

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.