

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040788

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 1189

FILED DEC 11 1961

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b	c. CITY OR TOWN SPRINGFIELD
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 924 N. Main Mary E. Wilson Home
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LYDIA Middle LOUISE Last VAN HOOSE			4. DATE OF DEATH Month December Day 2 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 24 Feb. 1870	9. AGE (last birthday) 91	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
-------------------------	----------------------------------	---	---	-------------------------------------	---------------------------	------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Springfield, Mo.	12. CITIZEN OF WHAT COUNTRY USA
--	---	---	---

13a. FATHER'S NAME Zachariah Van Hoose	13b. MOTHER'S MAIDEN NAME Mary Barrett	14. NAME OF HUSBAND OR WIFE None
--	--	--

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. No	17. INFORMANT John Ingram (Nephew) Chicago, Illinois	Address
---	--------------------------------------	--	---------

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 1 week
IMMEDIATE CAUSE (a)	Myocardial Infarction	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	Arteriosclerotic Heart Disease	
DUE TO (b)		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)	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 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 s.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 **1956** to **12/2/61** and last saw her alive on **7:30 am 12-2-61**
Death occurred at **8:43** a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) L. Richard Webb M.D.	22b. ADDRESS 609 Cherry Springfield, Missouri	22c. DATE SIGNED 12-4-61
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/4/61	23c. NAME OF CEMETERY OR CREMATORY Maple Park Cemetery	23d. LOCATION (City, town, or county) (State) Springfield, Missouri
--	-----------------------------	--	---

24. FUNERAL DIRECTOR KLINGNER MORTUARY, INC. SPRINGFIELD Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 12-5-61	26. REGISTRAR'S SIGNATURE Effie S. Melton
--	---------	--	---

jhc

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

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 John Klingman

Licensed Embalmer No. 5102

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.