

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044245

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1266

AMENDED
FILED DEC 26 1961

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Douglas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>	Length of stay in 1b <u>3 weeks</u>	c. CITY OR TOWN <u>Ava, Missouri</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Springfield Baptist</u>		d. STREET ADDRESS (If outside, give location) <u>Route 3</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Edward A</u> Middle <u>Herrell</u> Last <u>Herrell</u>	4. DATE OF DEATH Month <u>Dec.</u> Day <u>15</u> Year <u>1961</u>
--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-22-94</u>	9. AGE (last birthday) <u>66</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
--------------------	-------------------------------	---	----------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Marchant and Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Ava, Missouri</u>	11. BIRTHPLACE (City and state or country) <u>USA</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
--	--	---	--

13a. FATHER'S NAME <u>Ausburn Herrell</u>	13b. MOTHER'S MAIDEN NAME <u>Mattie Turner</u>	14. NAME OF HUSBAND OR WIFE <u>Bessie Herrell</u>
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W. W. One</u>	16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT Address <u>Bessie Herrell, R.3, Ava, Mo.</u>
---	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia, with cholecystitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Acute cholecystitis</u>	<u>3 wks.</u>
	DUE TO (c) <u>Cholelithiasis (cholecystotomy)</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Coronary thrombosis with aneurysm</u>	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 <u> </u> a.m. <u> </u> p.m. <u> </u>	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 <u>Nov. 1961</u> to <u>Dec. 15, 1961</u> and last saw her/him alive on <u>12-15-61</u> Death occurred at <u>2: P. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Gene W. Faulkner M.D.</u> (Degree or title)	22b. ADDRESS <u>1636 S. Graystone Springfield, Mo.</u>	22c. DATE SIGNED <u>12-18-61</u>
---	--	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-17-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Tabor</u>	23d. LOCATION (City, town, or county) (State) <u>R. Ava, Missouri</u>
---	---------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS <u>Clinkingbeard Funeral Home, Ava, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-19-61</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Meeten</u>
--	--	--

DATE AWENED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

DEC 27 1961

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 Lyle G. Glickingbeard

Licensed Embalmer No. 4830

P. O. Address Avon, 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.