

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044273

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1237

**FILED DEC 18 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> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		c. CITY OR TOWN <b>SPRINGFIELD</b>	
Length of stay in 1b <b>77 YRS.</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>ST. JOHN'S HOSP.</b>		d. STREET ADDRESS (If outside, give location) <b>825 S. KICKAPOO</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>GEORGIA McLAUGHLIN</b>			4. DATE OF DEATH Month <b>DEC.</b> Day <b>10</b> Year <b>1961</b>			
First	Middle		Last	Month	Day	

5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/22/79</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>LONOKE, ARKANSAS</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>GEORGE FORSYTH</b>	13b. MOTHER'S MAIDEN NAME <b>MARY NORTON</b>	14. NAME OF HUSBAND OR WIFE <b>HIRAM L. McLAUGHLIN (DEC.)</b>
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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 <b>MARGARET McLAUGHLIN, SPRINGFIELD, MO.</b>
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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: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis, Right Middle Cerebral Artery</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
DUE TO (b) <b>Cerebral Artery</b>		
DUE TO (c) <b>Generalized Arteriosclerosis</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic Heart Disease</b>		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"/> <b>None</b>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>none</b>
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20c. TIME OF INJURY Hour <b>none</b> a.m. p.m.	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 <b>SPRINGFIELD</b>	COUNTY <b>GREENE</b>	STATE <b>MO.</b>
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21. I attended the deceased from **6-27-51** to **12-10-61** and last saw her **alive** on **12-10-61**  
Death occurred at **4 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>W.D. Paul, M.D.</b>	(Degree or title)	22b. ADDRESS <b>609 Cherry, Springfield Mo.</b>	22c. DATE SIGNED <b>12/10/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>12/12/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HAZELWOOD</b>	23d. LOCATION (City, town, or county) <b>SPRINGFIELD, MO.</b>
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24. FUNERAL DIRECTOR <b>H.H. LOHMEYER FUNERAL HOME</b> ADDRESS <b>SPRINGFIELD, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>12-12-61</b>	26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>
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DATE AWIENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

**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 A. S. McCarver

Licensed Embalmer No. 2727

P. O. Address Appleton

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.