

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-006199

Dr. Park

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 363

**FILED MAR 12 1962**

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>		Length of stay in 1b <b>53 YRS.</b>	c. CITY OR TOWN <b>SPRINGFIELD</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>ST. JOHN'S HOSP.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>ROUTE # 6</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>FLOSSIE LIKINS</b>			4. DATE OF DEATH Month Day Year <b>MARCH 3 1962</b>		
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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>3/20/08</b>	9. AGE (last birthday) <b>53</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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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	11. BIRTHPLACE (City and state or country) <b>SPRINGFIELD, MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>JOHN EPPERSON</b>	13b. MOTHER'S MAIDEN NAME <b>ROSE ETTA GROVES</b>	14. NAME OF HUSBAND OR WIFE <b>BERTON B. LIKINS</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>	17. INFORMANT Address <b>BERTON B. LIKINS, 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) <u>Gastro Intestinal Hemorrhage, massive</u> DUE TO (b) <u>Ruptured Esophageal Varix</u> DUE TO (c) <u>Laennec's Cirrhosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> " <u>2 yrs.</u>
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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
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <b>NONE</b>	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.) <b>NONE</b>	20f. CITY, TOWN, OR LOCATION <b>SPRINGFIELD, MO.</b>
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21. I attended the deceased from <u>1955</u> to <u>3-3-62</u> and last saw her alive on <u>3-3-62</u> Death occurred at <u>1:05 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>W.D. Park, M.D.</u>	22b. ADDRESS <u>609 Cherry, Springfield, Mo.</u>	22c. DATE SIGNED <u>3/3/62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>3/6/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREENLAWN</b>	23d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD, MO.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>3-6-62</b>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>
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AMENDED  
 DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

**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 RR McCann

Licensed Embalmer No. 2729

P. O. Address Spfld 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.