

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-034444

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1444A

FILED OCT 3 1962

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Taney	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Length of stay in lb 1 Week	c. CITY OR TOWN Forsyth Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
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) Shadow Park Drive Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last James Clarence Root		4. DATE OF DEATH Month Day Year Sept 24-1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1 11 1894
9. AGE (last birthday) 68		IF UNDER 1 YEAR Months 8 Days 14 Hours Min. 	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Lumberman	11. BIRTHPLACE (City and state or country) Kirbyville Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME James G. Root	
13b. MOTHER'S MAIDEN NAME Mary May		14. NAME OF HUSBAND OR WIFE Bertha Root	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No War World War I		16. SOCIAL SECURITY NO. [Redacted]	
17. INFORMANT Bertha Root		Address Forsyth, Mo	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <input checked="" type="checkbox"/> Bronchogenic carcinoma, left upper lobe of lung with probable metastasis to brain DUE TO (b) Postoperative left upper lobectomy DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 6 weeks 2 days
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 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 9-17-62 to 9-24-62 and last saw him alive on 9-24-62 Death occurred at 4:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John W. Polk, M.D. (Degree or title)		22b. ADDRESS 315 Prof. Bldg., Springfield, Mo.	
22c. DATE SIGNED 9-28-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-27-62	23c. NAME OF CEMETERY OR CREMATORY Ozark Mem	23d. LOCATION (City, town, or county) (State) Brans on, Mo
24. FUNERAL DIRECTOR Walter Cobb		25. DATE RECD. BY LOCAL REG. 10-2-62	26. REGISTRAR'S SIGNATURE Effie S. Merton
ADDRESS Branson, Mo.			

John W. Polk, M.D.
USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF
15	440 WKI	No.
8	1-11-1894	1-11-18

DATE AMENDED
10-25-62
10-25-62

BY AFFIDAVIT OF Informant

MEDICAL CERTIFICATION

OCT 5 1962

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

Eric M. Abbott

Licensed Embalmer No.

5115

P. O. Address

Springfield, 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.

Vertical text on the right edge of the page, possibly a stamp or margin note.