

FILED JUL 7 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20147

BIRTH NO.		REG. DIST. NO. 128	PRIMARY REG. DIST. NO. 2000	Registrar's No. 625
1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene 1396		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield 0		
d. FULL NAME OF HOSPITAL OR INSTITUTION St Johns Hospital		d. STREET ADDRESS (If rural, give location) 1202 N Grant		
3. NAME OF DECEASED (Type or Print) Barbara		a. (First) Sue	b. (Middle) Mumford	c. (Last) 52
4. DATE OF DEATH (Month) (Day) (Year) 6 27		5. SEX Female		
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married		8. DATE OF BIRTH Jan. 26, 51
9. AGE (In years last birthday) 1 year		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY Child
11. BIRTHPLACE (City and State or Foreign Country) Springfield, Missouri 0		12. CITIZEN OF WHAT COUNTRY? U S		
13a. FATHER'S NAME Jack Mumford		13b. MOTHER'S MAIDEN NAME Barbara Seamen		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. None		17. INFORMANT'S SIGNATURE OR NAME Mrs Jack Mumford, Springfield
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hydrocephalus Gyina bifida II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 12 mo 17 mo
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 751x		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Jan 26, 1951, to Sep 1, 1951, that I last saw the deceased alive on Sept 1, 1951, and that death occurred at 11:45 Am., from the causes and on the date stated above.				
23a. SIGNATURE John P. Ferguson M.D.		23b. ADDRESS Springfield Mo		23c. DATE SIGNED 6-28-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/28/52	24c. NAME OF CEMETERY OR CREMATORY Hazelwood	24d. LOCATION (City, town, or county) (State) Springfield Mo.
DATE REC'D BY LOCAL REG. 7-1-52		REGISTRAR'S SIGNATURE Earl Williamsen Registrar		25. FUNERAL DIRECTOR'S SIGNATURE Mrs. Johnson Funeral Home Springfield

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

J. Ferguson

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
Student Embalmer

Signed James W. Wair

Licensed Embalmer No. 4650

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 this body is not embalmed, fact should be so stated above.