

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5529

State File No. ....

FILED FEB 16 1953

BIRTH NO. ....		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>161</u>	
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> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Springfield</u>		c. LENGTH OF STAY (In this place) .....		c. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>		0396	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2201 N. Boonville</u>				d. STREET ADDRESS (If rural, give location) <u>2201 N. Boonville</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ELIZABETH</u>		b. (Middle) .....		c. (Last) <u>WALTEMEYER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>February 12 1953</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>20 Nov. 1879</u>	
9. AGE (In years last birthday) <u>73</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>In Home</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John C. Glassel</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Abbie Sherman Springfield, Mo.</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Diabetes</u>  DUE TO (c) .....				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Don't know</u>	
19a. DATE OF OPERATION .....		19b. MAJOR FINDINGS OF OPERATION .....				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 <u>2-10-</u> , 19 <u>53</u> , to <u>2-12</u> , 19 <u>53</u> that I last saw the deceased alive on <u>2-11-</u> , 19 <u>53</u> , and that death occurred at <u>6:50A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>[Signature]</u> (Degree or title) .....				23b. ADDRESS <u>505 Med. Arts Bldg Springfield, Mo</u>		23c. DATE SIGNED <u>2-12-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) .....		24b. DATE <u>2/12/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Forest Hills Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>2-12-53</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J.W. KLINGNER &amp; CO. Springfield, Mo.</u>			

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

0396

**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

*Max Rhodes*

Licensed Embalmer No. *4071*

P. O. Address *Springfield*

**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.