

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DR. AMOS

5535

FILED MAR 9 - 1953

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>5465</u>		Registrar's No. <u>238</u>	
1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>UNKNOWN</u> b. COUNTY <u>UNKNOWN</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>RURAL SPRINGFIELD</u>		c. LENGTH OF STAY (In this place) <u>2 MO.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>UNKNOWN</u>		<u>0390</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>GREENE COUNTY FARM</u>				d. STREET ADDRESS (If rural, give location) <u>UNKNOWN</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ED.</u>		b. (Middle)		c. (Last) <u>ALKIRE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 5 1953</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>UNKNOWN</u>		8. DATE OF BIRTH <u>UNKNOWN</u>	
9. AGE (In years - last birthday) <u>ABOUT 80</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMES</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>UNKNOWN</u>	
12. CITIZEN OF WHAT COUNTRY <u>UNKNOWN</u>		13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT'S SIGNATURE OR NAME <u>COUNTY FARM RECORDS SPFLD, 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Mycocarditis, Chronic</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility</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>Dec 1952 to Mar 5, 1953</u> , that I last saw the deceased alive on <u>Mar 2, 1953</u> and that death occurred at <u>2:10 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Amos R. Amos</u> (Degree or title)				23b. ADDRESS <u>Greene County Court House Springfield, Missouri</u>			
23c. DATE SIGNED <u>3/7/53</u>							
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>3/7/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MT. TABOR</u>		24d. LOCATION (City, town, or county) (State) <u>ODESSA, MO.</u>	
DATE REC'D BY LOCAL REG. <u>3-6-53</u>		REGISTRAR'S SIGNATURE <u>Tracy Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H.H. LOHMEYER</u> ADDRESS <u>SPRINGFIELD, MO.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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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

Paul Schreyer

Licensed Embalmer No. *4734*

P. O. Address *Spital, MD*

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.