

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **998**

BIRTH NO. **FILED FEB 8 1954** REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **136**

| | | | |
|---|-----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Greene | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield | c. LENGTH OF STAY (in this place) | c. CITY OR TOWN Springfield | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 519 Cherry | | e. STREET ADDRESS (If rural, give location) 519 Cherry | |

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|---|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Margaret b. (Middle) S. c. (Last) Stiver | | | 4. DATE OF DEATH (Month) (Day) (Year) Feb. 5, 1954 | | |
|---|--|--|---|--|--|

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|----------------------|-------------------------------|---|---------------------------------------|---|------------------------|----------------------|-------|------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH June 14, 1865 | 9. AGE (In years last birthday) 88 | IF UNDER 1 YEAR Months | IF UNDER 4 HRS. Days | Hours | Min. |
|----------------------|-------------------------------|---|---------------------------------------|---|------------------------|----------------------|-------|------|

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|--|--|--|--|--|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (City and State or Foreign Country) Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA | |
|--|--|--|--|--|--|---|--|

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|---|--|---|--|--|--|
| 13a. FATHER'S NAME William Witherspoon | | 13b. MOTHER'S MAIDEN NAME Mary Watts | | 14. NAME OF HUSBAND OR WIFE Widowed | |
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|---|--|-------------------------------------|--|---|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Robert Price Springfield, Mo. | |
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|--|--|---|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i> | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart lesion | | | INTERVAL BETWEEN ONSET AND DEATH 10-12-53 |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Senility | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Entero colitis following appendectomy 1934 | | | |

| | | | | |
|------------------------|----------------------------------|--|---|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
|------------------------|----------------------------------|--|---|--|

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|--|--|--|--|---|--|
| 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) m. | | 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 **10-12-53**, 19**53**, to **2-4**, 19**54**, that I last saw the deceased alive on **2-4**, 19**54**, and that death occurred at **8:30P** m., from the causes and on the date stated above.

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|---|--|---|--|--------------------------------|--|
| 23a. SIGNATURE (Degree or title) C. E. Zeller M.D. | | 23b. ADDRESS 609 Cherry, Springfield, Missouri | | 23c. DATE SIGNED 2-6-54 | |
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|---|-------------------------------|--|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Feb. 7, 1954 | 24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery | 24d. LOCATION (City, town, or county) (State) Springfield, Missouri | | |
|---|-------------------------------|--|--|--|--|

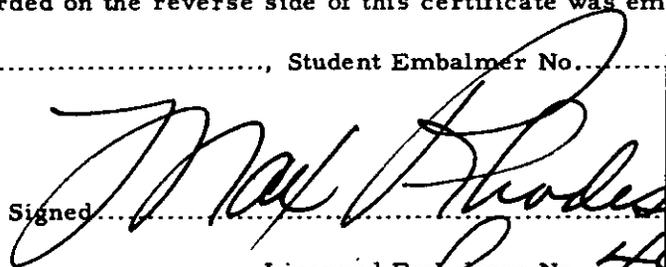
| | | | | | |
|--|---|--|--|--|--|
| DATE REC'D BY LOCAL REG. 2-6-54 | REGISTRAR'S SIGNATURE Edith Williamson | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.W. Klingner & Co. Springfield, Mo. | | | |
|--|---|--|--|--|--|

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

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 .....

Licensed Embalmer No. 40.....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.