

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4596**

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 271

| | | | |
|--|--|---|--|
| 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. CITY OR TOWN Springfield | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) | | e. STREET ADDRESS (If rural, give location) 1110 N. Prospect | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 1110 N. Prospect | | | |

| | | | | |
|-------------------------------------|-------------------------|-----------------------|------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) ROXIE | b. (Middle) E. | c. (Last) WILEY | 4. DATE OF DEATH (Month) (Day) (Year) March 9, 1954 |
|-------------------------------------|-------------------------|-----------------------|------------------------|---|

| | | | | | | | |
|-------------------------|----------------------------------|--|---|--|---------------------------|---------------------------|-------------------------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH 19 Oct. 1878 | 9. AGE (In years last birthday) 75 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Hours | IF UNDER 1 MIN. Min. |
|-------------------------|----------------------------------|--|---|--|---------------------------|---------------------------|-------------------------|

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

| | | |
|--|---|--|
| 13a. FATHER'S NAME Jesse Lynch | 13b. MOTHER'S MAIDEN NAME Mattie Haynes | 14. NAME OF HUSBAND OR WIFE Deceased |
|--|---|--|

| | | | |
|---|--------------------------------------|---|-----------------------------------|
| 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. No | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Lehman Stephen | ADDRESS Springfield, Mo |
|---|--------------------------------------|---|-----------------------------------|

| | | | |
|--|--|--|---|
| 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, ashenia, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs years |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. arteriosclerosis | | |
| | DUE TO (b) _____ DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

| | | |
|------------------------|--|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 332 X | 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) 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 Sept 19 48 to Mar 9, 1954, that I last saw the deceased alive on Mar 8, 1954, and that death occurred at 2:15 P m., from the causes and on the date stated above.

| | | | |
|---|-----------------------------------|--|------------------------------------|
| 23a. SIGNATURE <i>W. D. Williams</i> | (Degree or title) m. D. | 23b. ADDRESS Medical Arts Bldg. Springfield, Mo. | 23c. DATE SIGNED 3-10-54 |
|---|-----------------------------------|--|------------------------------------|

| | | | |
|--|-----------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 3-11-54 | 24c. NAME OF CEMETERY OR CREMATORY Eastlawn Cemetery | 24d. LOCATION (City, town, or county) (State) Springfield, Missouri |
|--|-----------------------------|--|---|

| | | | |
|--|--|---|------------------------------------|
| DATE REC'D BY LOCAL REG. 3-10-54 | REGISTRAR'S SIGNATURE <i>Edith Williamson</i> | 25. FUNERAL DIRECTOR'S SIGNATURE <i>John Klingner Co</i> | ADDRESS 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.....
Max F. Hodge

Licensed Embalmer No. *40*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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