

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29627**

FILED AUG 17 1954

BIRTH NO. _____ REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 6225 Registrar's No. 226

1. PLACE OF DEATH
a. COUNTY Vernon

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Greene

b. CITY OR TOWN Washington Sup. c. LENGTH OF STAY (in this place) 27-9-13

c. CITY OR TOWN Springfield d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital # 3

e. STREET ADDRESS 7112 W. Water 0396
1

3. NAME OF DECEASED (Type or Print)
a. (First) JOSEPH. b. (Middle) — c. (Last) DANFOYTH

4. DATE OF DEATH (Month) (Day) (Year)
8. 1. 54

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single - 0

8. DATE OF BIRTH 6. 23. 1903

9. AGE (In years last birthday) 51
IF UNDER 1 YEAR: Months 1 Days 11
IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country) Stafford Mo

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME William Doupré

13b. MOTHER'S MAIDEN NAME Almeda Clause

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) Unknown

16. SOCIAL SECURITY NO. None

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Mrs W.D. Doupré 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, asphyxia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tuberculosis of Bone

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
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.

INTERVAL BETWEEN ONSET AND DEATH
2 yrs +

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION 0123

20. AUTOPSY? YES NO

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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-1-1946, to 8-3-1954, that I last saw the deceased alive on 8-2-1954 and that death occurred at 720 P.M., from the causes and on the date stated above.

23a. SIGNATURE J.P. Bunch M.D. (Degree or title)

23b. ADDRESS State Hospital # 3

23c. DATE SIGNED 8-3-54

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE 8-4-54

24c. NAME OF CEMETERY OR CREMATORY Danforth Cemetery

24d. LOCATION (City, town, or county) (State) Greene County Mo.

DATE REC'D BY LOCAL REG. 8-12-54

REGISTRAR'S SIGNATURE Anna E. Ferry

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Kingman Funeral Home - 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. 522 working under my personal supervision..

Student Francis C. Marsh
Signature of Student Embalmer

Signed Derey F. Melster

Licensed Embalmer No. 486

P. O. Address Nevada

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.