

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21790

State File No. ....

FILED JUL 18 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 607

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>SPRINGFIELD</b>	c. LENGTH OF STAY (In this place) <b>60 yrs</b>	c. CITY OR TOWN <b>SPRINGFIELD</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>1047 W. HAMILTON</b>		e. STREET ADDRESS (If rural, give location) <b>1047 W. HAMILTON</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>MARY</b> b. (Middle) <b>LOUISE</b> c. (Last) <b>EASLEY</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>JULY 9, 1955</b>
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>NOV. 18, 1856</b>	9. AGE (In years last birthday) <b>98</b>	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work from which most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>IN HOME</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>JOSEPH A. RENSHAW</b>	13b. MOTHER'S MAIDEN NAME <b>SARAH SUSAN GRIFFIS</b>	14. NAME OF HUSBAND OR WIFE <b>WIDOWED</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>MRS EUGENIE McALLISTER, SPFD. MO.</b>
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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		INTERVAL BETWEEN ONSET AND DEATH  <b>NOT KNOWN</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arterio Sclerotic Heart Disease</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____ DUE TO (c) <b>4200</b>		
	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 _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____
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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? _____
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22. I hereby certify that I attended the deceased from 5-14, 1951, to 7-9, 1955, that I last saw the deceased alive on 7-7, 1955, and that death occurred at 6:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Type or Print) <b>Max Fitch</b>	(Occupation or Title) <b>M.D.</b>	23b. ADDRESS <b>Springfield Mo</b>	23c. DATE SIGNED <b>7-9-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>7-11-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>GREENLAWN CEMETERY</b>	24d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD, MISSOURI</b>
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DATE REC'D BY LOCAL REG <b>7-13-55</b>	REGISTRAR'S SIGNATURE <b>E. W. Williamson</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J. W. Knigge &amp; Co SPRINGFIELD, MISSOURI</b>
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(Licensed Embalmers' Statement on Reverse Side) *mda*

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 Rhodes*

Licensed Embalmer No. 40

P. O. Address *Spring*

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