

FILED OCT 31 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32897

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 944

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Oklahoma</u> b. COUNTY <u>Texas</u>	
b. CITY OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Hooker</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <u>10</u>
c. LENGTH OF STAY (in this place) <u>12 days</u>		e. STREET ADDRESS (If rural, give location) <u>Route 4-Box 3</u> <u>35</u> <u>6</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Johns Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>Lorenzo</u> c. (Last) <u>Whitney</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 24-1955</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>March 22-1887</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 14 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Bolivar-Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Seymour Whitney</u>	13b. MOTHER'S MAIDEN NAME <u>Adalaid Ward</u>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give year or date of service) <u>Yes World War I</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Alta Ward-Optima</u> ADDRESS <u>Okla.</u>
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hemorrhage, stomach</u>		<u>5 days</u>
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>① Fracture, comminuted right forearm</u> <u>② Fracture, right 4th rib</u>		<u>12 days</u>

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.) <u>Highway</u>	21c. (CITY, TOWN, OR TOWNSHIP) <u>Springfield</u> (COUNTY) <u>Greene</u> (STATE) <u>Missouri</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Oct. 12 1955 A.M.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Auto accident on Highway</u>
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22. I hereby certify that I attended the deceased from 10/12/55, to 10/24/55, 1955, that I last saw the deceased alive on 10/23, 1955, and that death occurred at 5:45 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Dr. D. Horton M.D.</u> (Degree or title)	23b. ADDRESS <u>Springfield, Mo.</u>	23c. DATE SIGNED <u>10/24/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10-26-55</u>	24c. NAME OF CEMETERY OR CREMATOR <u>NATIONAL CEMETERY</u>	24d. LOCATION (City) town, or county (State) <u>Springfield, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>10-25-55</u>	REGISTRAR'S SIGNATURE <u>Edith Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Ray J. Jolley</u> ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

NOV 18 1954

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. 33

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.