

FILED SEP 24 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30360

STATE FILE NUMBER

57474-57 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 847

| | | | |
|--|----------------------------------|---|--|
| 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, give TOWNSHIP only) OR TOWN Springfield | | c. CITY OR TOWN Springfield 0396 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital | | d. STREET (If outside, give location) ADDRESS 1423 N. Jefferson | |
| Length of stay in 1b 14 Hours | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Bobby Middle Dean Last Arrison | | | 4. DATE OF DEATH Month September Day 17 Year 1956 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/17/1956 |
| 9. AGE (In years last birthday) | | IF UNDER 1 YEAR Months — Days — Hours 14 Min. — | IF UNDER 24 HRS. Hours — Min. — |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (City and state or country) Springfield, Mo. |
| 13. FATHER'S NAME Robert Arrison | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 14. MOTHER'S MAIDEN NAME Bertha Deckard | |
| 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Robert Arrison 315 N. Farmer St. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital atelectasia DUE TO (b) Premature Birth DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sipencephalin | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 7625 | |
| 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____ | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |
| 21. I attended the deceased from 1-17-56 to 1-17-56 and last saw her/him alive on 1-17-56 Death occurred at 11:10 P m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Urban J. Busiek (Degree or title) M.D. | | 22b. ADDRESS 609 Cherry Street | |
| 22c. DATE SIGNED 9/19/56 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 9/19/1956 | 23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery | 23d. LOCATION (City, town, or county) (State) Springfield, Missouri |
| 24. FUNERAL DIRECTOR Ayre-Goodwin Springfield, Mo. | | 25. DATE RECD. BY LOCAL REG. 9-20-56 | 26. REGISTRAR'S SIGNATURE Edith Williams |

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

300
1-56Health,
Welfare
Public
Service

(Licensed Embalmer's Statement on Reverse Side)

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 *James W. Wair*.....

Licensed Embalmer No. *465*
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.