

Dr. *Russell*

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1001

STATE FILE NUMBER

FILED FEB 4 1957

 Registration District No. *128* Primary Registration District No. *2000* Registrar's No. *102*

1. PLACE OF DEATH a. COUNTY Greene			2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Missouri b. COUNTY Greene		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Handley Hosp.		Length of stay in 1b 35 Yrs.	d. STREET ADDRESS (If outside, give location) 831 E. Normal		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MAE Middle PARSLEY Last PARSLEY			4. DATE OF DEATH Month Jan. Day 28 Year 1957		
5. SEX Female	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 Nov. 8 1899	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months 57 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Milliner		10b. KIND OF BUSINESS OR INDUSTRY Milliner	11. BIRTHPLACE (City and state or country) Batesville, Ark.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME David L. Parsley			14. MOTHER'S MAIDEN NAME Maude Stephens		
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. Unknown	17. INFORMANT Address Elmer J. Parsley Spfld, Mo.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE - (a) Small Bowel Obstruction DUE TO (b) Intestinal C.A. 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 (n) Fracture of Hip					INTERVAL BETWEEN ONSET AND DEATH 20 hrs ?
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.) 153XF			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____					
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 1-5-57 to 1-28-57 and last saw her alive on 1-29-57 Death occurred at 2:10 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Dee or title) <i>Earl Q. Russell</i>		22b. ADDRESS 1503 S. Pleasant Springfield, Mo		22c. DATE SIGNED 1-31-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/30/57		23c. NAME OF CEMETERY OR CREMATORIUM Greenlawn	
		23d. LOCATION (City, town, or county) Springfield, Mo.		(State)	
24. FUNERAL DIRECTOR H.H. Lohmeyer		ADDRESS Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 1-31-57	
		26. REGISTRAR'S SIGNATURE <i>Edith Williams</i>			

(Licensed Embalmer's Statement on Reverse Side)

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 *W. L. McCann*.....

Licensed Embalmer No. *27*.....

P. O. Address *Springfield*.....

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