

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12750

STATE FILE NUMBER

FILED APR 29 1957

Registration District No.

128

Primary Registration District No.

2000

Registrar's No.

397

S. 300
1-57

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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1623 IRVING Foster Rest Home		Length of stay in lb 56 Yrs.	d. STREET ADDRESS RFD#5 (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HELEN Middle SUE Last BILLS			4. DATE OF DEATH April 25, 1957 Month Day Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 Oct. 1872		9. AGE (In years) 84 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME J. T. Pattie		13b. MOTHER'S MAIDEN NAME Annie Sargent		14. NAME OF HUSBAND OR WIFE Clyde Bills (Deceased)	
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. No	17. INFORMANT Noel Bills Address Springfield, 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) Coronary Arterial Vascular Disease					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) Oshtete Mellitus					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 Apr 4-1955 , to Apr 25-57 and last saw ^{her} him alive on Apr 24 1957 Death occurred at 7:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Max Nett (Degree or title) M.D.			22b. ADDRESS Spgrd. Medical Bldg. Springfield, Missouri		22c. DATE SIGNED 4-26-57
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial	23b. DATE 4-27-57	23c. NAME OF CEMETERY OR CREMATORY Greenlawn		23d. LOCATION (City, town, or county) (State) Springfield, Missouri	
24. FUNERAL DIRECTOR J.W. Klingner & Co. ADDRESS Spgrd. Mo.		25. DATE RECD. BY LOCAL REG. 4-26-57	26. REGISTRAR'S SIGNATURE Edith Williamson		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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 *Glen D. Williams*

Licensed Embalmer No. *4651*
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.