

Dr/ Ferrell

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16760

STATE FILE NUMBER

FILED MAY 20 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 451

1. PLACE OF DEATH a. COUNTY Greene			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Missouri b. COUNTY Howell		
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 Hocomo		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hosp.		Length of stay in lb 3 Days	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOE Middle AMBERS Last NORTH			4. DATE OF DEATH Month May Day 11 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17 1876	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (City and state or country) Osark County, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Archibald North			14. MOTHER'S MAIDEN NAME Comfort Cope		
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 Susan North Hocomo, 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) arterio-sclerotic Heart 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((n) 4200					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 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 5/8/57 to 5/11/57 and last saw her alive on 5/11/57 Death occurred at 3:50 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Thomas E. Ferrell M.D.			22b. ADDRESS Springfield Mo		22c. DATE SIGNED 5/13/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5/12/57	23c. NAME OF CEMETERY OR CREMATORY West Plains, Mo.		23d. LOCATION (City, town, or county) (State) West Plains, Mo.
24. FUNERAL DIRECTOR Thornburgh Funeral Home West Plains Mo.		ADDRESS	25. DATE RECD. BY LOCAL REG. 5-14-57		26. REGISTRAR'S SIGNATURE Edith Williams

Health,
& Welfare
S. Public
th ServiceS. 300
v. 1-56

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

OCT 17 1951

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 *H. L. McCann*.....

Licensed Embalmer No. *272*

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.