

Dr. Williams  
FILED SEP 30 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31432  
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 917

1. PLACE OF DEATH a. COUNTY <b>Greene</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Polk</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Bolivar</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mercy Hosp.</b>		Length of stay in 1b <b>5 Days</b>	d. STREET ADDRESS (If outside, give location) <b>Buffalo, St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>IRVEN</b> Middle <b>LEE</b> Last <b>GREGG</b>			4. DATE OF DEATH <b>Sept. 20 1957</b> Month Day Year		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 30 1879</b>	9. AGE (In years last birthday) <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETD. POSTAL CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. MAIL SERVICE</b>		11. BIRTHPLACE (City and state or country) <b>LADOGA, INDIANA</b>	
13. FATHER'S NAME <b>WILLIAM HUBBARD GREGG</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Homer Gregg</b> Address <b>Independence, Kan.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u><i>Tuberculosis - adenitis</i></u>  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 (a) <u><i>Malnutrition - marked.</i></u>					INTERVAL BETWEEN ONSET AND DEATH
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.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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 <u><i>9-15-57</i></u> to <u><i>9-20-57</i></u> and last saw <sup>him</sup> alive on <u><i>9-15-57</i></u> Death occurred at <u><i>8:30 p.m.</i></u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u><i>Johnnie J. M. D.</i></u>			22b. ADDRESS <u><i>Springfield Mo</i></u>		22c. DATE SIGNED <u><i>9-21-57</i></u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u><i>Removal</i></u>		23b. DATE <u><i>9/22/57</i></u>	23c. NAME OF CEMETERY OR CREMATORY <u><i>Oak Hill</i></u>		23d. LOCATION (City, town, or county) (State) <u><i>Lawrence Kansas</i></u>
24. FUNERAL DIRECTOR <u><i>H.H. Lohmeyer</i></u>		ADDRESS <u><i>Springfield, Mo.</i></u>		25. DATE RECD. BY LOCAL REG. <u><i>9-24-57</i></u>	26. REGISTRAR'S SIGNATURE <u><i>Frank Williams</i></u>

OCT 17 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *H. L. McCaine*

Licensed Embalmer No. *27*

P. O. Address *Springfield*

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

*Mc*