

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

35492

STATE FILE NUMBER

FILED OCT 21 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 992

S. 300  
1-57

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>Greene</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>Springfield</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>Burge Hospital</b>			Length of stay in 1b <b>50 Yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>1008 E. Brower</b>			Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>PETERSON</b> Last <b>PETERSON</b>				4. DATE OF DEATH Month <b>October</b> Day <b>14</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>30 Oct. 1877</b>	9. AGE (In years last birthday) <b>79</b>	10. UNDER 1 YEAR Months <b>3</b> Days <b>9</b>	11. UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Peter Johnson</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war and dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT <b>Hospital Records</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) <b>Cerebral Thrombosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cylindrical thrombosis of Basilar artery with cerebral-malacia</b>	DUE TO (c) <b>Systemic Arterio-Sclerosis 332X</b>	3-5 days	8-10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cystitis acuta</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <b>8:45</b> Month <b>8</b> Day <b>1</b> Year <b>57</b> a.m. p.m.							
20d. INJURY OCCURRED WHILE AT <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 <b>7-1-57</b> to <b>10-14-57</b> and last saw her alive on <b>Oct 14, 1957</b> Death occurred at <b>8:45 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>M.L. Benton M.D.</i>				22b. ADDRESS <b>Springfield, Missouri</b>		22c. DATE SIGNED <b>10-15-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-16-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Springfield, Missouri</b>			
24. FUNERAL DIRECTOR <i>H.W. Klingner &amp; Co.</i>			ADDRESS <b>Spgrfd. Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>10-15-57</b>		26. REGISTRAR'S SIGNATURE <i>Paula Williams</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standardized nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Green	Green	Green	Green
X	X	X	X
October 11, 1927	October 11, 1927	October 11, 1927	October 11, 1927
Female	Female	Female	Female
White	White	White	White
Home	Home	Home	Home
Unknown	Unknown	Unknown	Unknown
Deceased	Deceased	Deceased	Deceased
USA	USA	USA	USA
30 Oct. 1897	30 Oct. 1897	30 Oct. 1897	30 Oct. 1897
to	to	to	to
to	to	to	to
to	to	to	to

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 *Mal P. Prodes* .....

Licensed Embalmer No. *4071* .....  
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.