

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 13 1957

40006

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1164

1. PLACE OF DEATH a. COUNTY Greene			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY Baxter		
b. CITY (If outside corporate limits, give TOWNSHIP only) Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Bassville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA St. John's Hospital			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 803
3. NAME OF DECEASED (Type or print) First GROVER Middle W Last SQUIRES			4. DATE OF DEATH Month Dec Day 5 Year 1957		
5. SEX Male	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 8-3-88	9. AGE (In years last birthday) 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk Missouri		10b. KIND OF BUSINESS OR INDUSTRY Pacific R. R.		11. BIRTHPLACE (City and state or country) Clay County, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William W. Squires			14. MOTHER'S MAIDEN NAME Emma Tipel		
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. ?		17. INFORMANT Address Mrs. Omler Nessary, Buckner, Missouri	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probably Coronary Occlusion					INTERVAL BETWEEN ONSET AND DEATH Instant
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 IMMEDIATE DISEASE CONDITION GIVEN IN PART I (n)					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.) UNATTENDED BY A PHYSICIAN		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____			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 _____ to _____ and last saw her alive on _____ Death occurred at about 9 p _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) James R. Omler		22b. ADDRESS Greene County Health Dept. Springfield, Missouri		22c. DATE SIGNED 12/6/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12/6/57	23c. NAME OF CEMETERY OR CREMATORY Floral Hills		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR ADDRESS H. H. Lohmeyer, Springfield, Missouri		25. DATE RECD. BY LOCAL REG. 12/6/57		26. REGISTRAR'S SIGNATURE Edith Williamson	

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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 *H. L. McCarroll*.....

Licensed Embalmer No. 272

P. Springfield
Address

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.