Health, Welfare Public Service

300
1-57

FILED MAR 3 - 1958

THE DIVISION OF HEALTH OF MISSOURI 90965-57

STANDARD CERTIFICATE OF DEATH

58-005194
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 5457 Registrar's No. 170B

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Cave Springs — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Home — Length of stay in 1b life

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Greene
c. CITY OR TOWN Cave Springs 0390 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) none — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Diana Middle Lynn Last Cotter

4. DATE OF DEATH Month 2 Day 19 Year 1958

5. SEX F
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH 12-28-1957
9. AGE (In years last birthday) 0 — IF UNDER 1 YEAR Months 1 Days 23 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (City and state or country) Springfield, Mo.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Harold Gene Cotter
13b. MOTHER'S MAIDEN NAME Barbra Miller
14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. nonen
17. INFORMANT H.D.Cotter Address Cave Springs, Mo.

MEDICAL CERTIFICATION

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 Bronchial Pneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) UNATTENDED BY A PHYSICIAN
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 491X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

Death occurred at 8:30 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE James R. Amos, M.D. Health Officer
22b. ADDRESS Greene County Court House Springfield, Missouri
22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 2-21-1958
23c. NAME OF CEMETERY OR CREMATORY Squibb Cemetery
23d. LOCATION (City, town, or county) (State) Greene County Missouri

24. FUNERAL DIRECTOR ADDRESS Cantrell-Fossett Republic, Mo.
25. DATE RECD. BY LOCAL REG. 2-24-58
26. REGISTRAR'S SIGNATURE Effie G. Melton

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 William B. Cantrell

Licensed Embalmer No. 8720

P. O. Address Republic

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.