

Health, Welfare, Public Service

Dr. K. Knabb

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-009640

STATE FILE NUMBER

FILED APR 7 1958

Registration District No. 128 Primary Registration District No. 5465 Registrar's No. 335

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1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene 0390	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Springfield Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Art # 2 Box # 244		Length of stay in lb 45 Yrs.	d. STREET ADDRESS (If outside, give location) Route # 2 Box # 244 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MARY Middle ETTA Last PACKER			4. DATE OF DEATH Month March Day 29 Year 1958		
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5. SEX Female	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 July 25 1863	9. AGE (In years last birthday) 94	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Lee County, Iowa	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Obed King	13b. MOTHER'S MAIDEN NAME Nancy Trueblood	14. NAME OF HUSBAND OR WIFE I.L. Packer (Dec.)
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. No	17. INFORMANT Mrs. Gladys Lyons	Address Springfield, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Physical Deterioration		INTERVAL BETWEEN ONSET AND DEATH Unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerosis, General	
	DUE TO (c) Unattended by a physician 4500	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
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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
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21. I attended the deceased from _____ to _____ and last saw him alive on _____
Death occurred at **About 11:30 a.m.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE James P. Moore (Degree or title) 5	22b. ADDRESS Health Officer, Greene County	22c. DATE SIGNED 4-2-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/31/58	23c. NAME OF CEMETERY OR CREMATORY Greenlawn	23d. LOCATION (City, town, or county) (State) Springfield, Mo.
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24. FUNERAL DIRECTOR H.H. Lohmeyer	ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 4-2-58	26. REGISTRAR'S SIGNATURE Offie G. Meeton
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *AT McCann*

Licensed Embalmer No. *3723*

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.