Dr. J. Williams

Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-028792
STATE FILE NUMBER

FILED SEP 15 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 875

1. PLACE OF DEATH
a. COUNTY GREENE
b. CITY OR TOWN SPRINGFIELD — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) FOSTER NURSING HOME — Length of stay in 1b 1 YR.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY GREENE
c. CITY OR TOWN SPRINGFIELD 0396 0 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 1111 MT. VERNON — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First STEPHEN Middle W. Last DAILY

4. DATE OF DEATH Month SEPT. Day 7, Year 1958

5. SEX MALE 0

6. COLOR OR RACE WHITE

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH SEPT. 4 1879

9. AGE (In years last birthday) 79 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED

10b. KIND OF BUSINESS OR INDUSTRY FARMER

11. BIRTHPLACE (City and state or country) SUMNER COUNTY, KANSAS 1

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME JAMES DAILY

13b. MOTHER'S MAIDEN NAME MARTHA HEATHMAN

14. NAME OF HUSBAND OR WIFE X

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. ?

17. INFORMANT MRS. OLIVE WESTMORELAND Address SPRINGFIELD, 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) Cancer of the Prostate — INTERVAL BETWEEN ONSET AND DEATH 2½ yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 177X
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 [ ] NO [ ] 0

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

21. I attended the deceased from Aug 15 1957, to Sept 7 1958 and last saw him alive on 9-5-58
Death occurred at 4:45 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [illegible] M.D.

22b. ADDRESS Springfield

22c. DATE SIGNED 9-8-58

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL

23b. DATE 9/8/58

23c. NAME OF CEMETERY OR CREMATORY COUNCIL HILL

23d. LOCATION (City, town, or county) (State) NEAR, BELLE PLAINE, KAN.

24. FUNERAL DIRECTOR H.H. LOHMEYER ADDRESS SPRINGFIELD, MO.

25. DATE RECD. BY LOCAL REG. 9-8-58

26. REGISTRAR'S SIGNATURE Effie G. Melton

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ..... Signed R L McCann
Signature of Student Embalmer

Licensed Embalmer No. 2727

P. O. Address Springfield, M

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.