

pt. Health,  
, & Welfare  
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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.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036120  
STATE FILE NUMBER

John L K Tsang, M.D.

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1037  
FILED NOV 3 1958

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>St. John's Hosp.</b>		Length of stay in lb	d. STREET ADDRESS <b>0396 636 S. Market</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EVERETT ROBERT WHITE</b>			4. DATE OF DEATH Month Day Year <b>Oct. 27, 1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 7, 1937</b>	9. AGE (In years last birthday) <b>21</b> 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) <b>meat wrapper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>	11. BIRTHPLACE (City and state or country) <b>Springfield, Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Orland Hubert White</b>		13b. MOTHER'S MAIDEN NAME <b>Ila M. Powell</b>		14. NAME OF HUSBAND OR WIFE <b>Betty White, Springfield</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>494-36-4465</b>	17. INFORMANT <b>Betty White</b>		Address <b>Springfield, Mo.</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 Hemorrhage</b> DUE TO (b) <b>Cerebral Edema</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>9199 43</b>					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)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input checked="" 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.) <b>#22 Rifle bullet entering skull</b>				
20c. TIME OF INJURY Hour Month, Day, Year <b>4:00 pm 10-26-58</b>						
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> WORK AT WORK		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, pdg., etc.) <b>Stafford</b>	20f. CITY, TOWN, OR LOCATION <b>Stafford</b>		COUNTY <b>Greene</b>	
21. I attended the deceased from Death occurred at <b>6:00 A.M.</b>		to <b>10-26-58</b> , to <b>10-27-58</b> and last saw her him alive on <b>10-27-58</b>		on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <b>John L K Tsang M.D.</b>		22b. ADDRESS <b>1636 S. Pleasant, Springfield</b>		22c. DATE SIGNED <b>10-29-58</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/29/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Salem Cemetery</b>		23d. LOCATION (City, town, or county) <b>Mt. Vernon, Mo.</b>		
24. FUNERAL DIRECTOR <b>Max L. Fossett, Mt. Vernon, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>10-30-58</b>		26. REGISTRAR'S SIGNATURE <b>Effie E. Melton</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

NOV 5 1958

NOV 4 1958

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 Wayne Smith....., Student Embalmer No. 567..... working under my personal supervision.

Student Wayne Smith.....  
Signature of Student Embalmer

Signed L. Mason.....

Licensed Embalmer No. 4568.....

P. O. Address Springdale, Va

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.