Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-039622
STATE FILE NUMBER

FILED DEC 15 1958 Registration District No. 128 Primary Registration District No. 200 Registrar's No. 1193

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY OR TOWN Springfield Mo — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 1800 College t — Length of stay in Hospital 2days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Dade
c. CITY OR TOWN So. Greenfield Mo. 0290 0 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First Flora Middle Alnora Last Underwood

4. DATE OF DEATH: Month Dec Day 9 Year 1958

5. SEX Female 1
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]
8. DATE OF BIRTH Oct 16 1886
9. AGE (In years last birthday) 72 — 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) House Wife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Dade Co Mo 0
12. CITIZEN OF WHAT COUNTRY? usa

13a. FATHER'S NAME C.C Burney
13b. MOTHER'S MAIDEN NAME Martha Howell
14. NAME OF HUSBAND OR WIFE Alcander Underwood

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. none
17. INFORMANT Lucille Gillick Address Springfield Mo

MEDICAL CERTIFICATION — USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probable Coronary
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) occlusion. No one
DUE TO (c) present at the time, 4201

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 [X] 2
for asthma bronchitis for years

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 Jan. 1 - 58 to 12 9.58 and last saw her/him alive on Dec - 1 - 58
Death occurred at 5:00A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W. L. Burney M.D. (Degree or title)
22b. ADDRESS Miller, Mo
22c. DATE SIGNED 12-16-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Dec 12 1958
23c. NAME OF CEMETERY OR CREMATORY Sinking Creek
23d. LOCATION (City, town, or county) (State) Dade Co Mo.

24. FUNERAL DIRECTOR W.R. Allison ADDRESS Greenfield Mo.
25. DATE RECD. BY LOCAL REG. 12-12-58
26. REGISTRAR'S SIGNATURE Effie E. Melton

(Licensed Embalmer's Statement on Reverse Side)

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 W. R. Allison

Licensed Embalmer No. 4404

P. O. Address Greenville Dr

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.