

Dr. Wakeman

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-043761

STATE FILE NUMBER

FILED DEC 22 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1215

300  
1-57

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> 0396 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>DOA Burge Hosp.</b>		Length of stay in 1b <b>26 Yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>2302 W. Kearney</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>C.</b> Last <b>BEAN</b>			4. DATE OF DEATH Month <b>DEC.</b> Day <b>15</b> Year <b>1958</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 25 1899</b>	9. AGE (In years last birthday) <b>59</b>	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) <b>FILLING STATION OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OPERATOR</b>	11. BIRTHPLACE (City and state or country) <b>UNKNOWN 9</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>UNKNOWN</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE <b>ALTA BEAN (DEC.)</b>	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>?</b>	17. INFORMANT <b>MARETTA WARREN</b> Address <b>SPRINGFIELD, MO.</b>	
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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) <b>Coronary Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>hour</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Generalized arteriosclerosis mod</b>		
	DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4201</b>			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.) <b>4201</b>		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			

20d. INJURY OCCURRED WHILE AT <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 <b>Springfield, Mo</b>	COUNTY <b>Greene</b>	STATE <b>MO.</b>
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21. I attended the deceased from <b>8-19-58</b> to <b>Dec 15 1958</b> and last saw him alive on <b>Nov 5, 1958</b> Death occurred at <b>8:57 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>J. Newton Wakeman MD</b> (Degree or title)	22b. ADDRESS <b>Springfield, Mo</b>	22c. DATE SIGNED <b>12-15-58</b>
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23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <b>Burial</b>	23b. DATE <b>12/17/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HIGHLANDVILLE CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>HIGHLANDVILLE, MO.</b>
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24. FUNERAL DIRECTOR <b>H.H. LOHMEYER</b> ADDRESS <b>SPRINGFIELD, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>12-16-58</b>	26. REGISTRAR'S SIGNATURE <b>Offis G. Melton</b>
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(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.

JAN 7 1959

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 PA Mc O...

Licensed Embalmer No. 2727

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.