

Health,
Welfare
Public
Service

Dr. Simpson

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001043

STATE FILE NUMBER

FILED FEB 9 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 115

300
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY GREENE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE MISSOURI b. COUNTY GREENE | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN SPRINGFIELD 0396 |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OF VOLKNER NURSING HOME | | Length of stay in lb 87 YRS. | d. STREET ADDRESS 821 BENTON |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | |
|--|--------------|----------------|------------------|-----------|--------------|
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | | |
| First WILLIAM | Middle A. | Last WARDEN | Month JAN. | Day 31 | Year 1959 |

| | | | | | | |
|------------------|---------------------------|---|---------------------------------|---------------------------------------|--------------------------------|--------------------------------|
| 5. SEX MALE 0 | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 24 1871 | 9. AGE (In years less birthday) 87 | 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) RETIRED | 10b. KIND OF BUSINESS OR INDUSTRY FRISCO R.R. | 11. BIRTHPLACE (City and state or country) SPRINGFIELD, MO. | 12. CITIZEN OF WHAT COUNTRY? USA |
|--|--|--|-------------------------------------|

| | | |
|------------------------------------|---|---|
| 13a. FATHER'S NAME JAMES WARDEN | 13b. MOTHER'S MAIDEN NAME MARTHA McBRIDE | 14. NAME OF HUSBAND OR WIFE MARY B. WARDEN |
|------------------------------------|---|---|

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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) NO | 16. SOCIAL SECURITY NO. ? | 17. INFORMANT MRS. MARY B. WARDEN | 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) <u>Arteriosclerotic Heart Disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>15 mo.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. | DUE TO (b) <u>Generalized Arteriosclerosis</u> | <u>15 mo</u> |
| | DUE TO (c) <u>Senility</u> | |
| 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"/> |

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| 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.) |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | |

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|---|--|---|
| 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 COUNTY STATE |
|---|--|---|

21. I attended the deceased from 8-31-57 to 1-31-59 and last saw him alive on 1-31-59
Death occurred at 12 am on the date stated above; and to the best of my knowledge, from the causes stated.

| | | |
|---|--|-----------------------------------|
| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) | 22b. ADDRESS <u>Springfield Mo.</u> | 22c. DATE SIGNED <u>2-2-59</u> |
|---|--|-----------------------------------|

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|---|---------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 2/2/59 | 23c. NAME OF CEMETERY OR CREMATORY HAZELWOOD | 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. 2-3-59 | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> |
|---------------------------------------|-----------------------------|--|---|

All diseases in Part I must be causally related.

1959 FEB 9 6 33J

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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 *Gene A. Hunkler*

Licensed Embalmer No. *44739*

P. O. Address *317 1/2*

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.