

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013030

FILED APR 20 1959

Registration District No. 128 Primary Registration District No. 2000 STATE FILE NUMBER Registrar's No. 377

300
1-57

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Springfield	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1429 Roanoke		d. STREET ADDRESS (If outside, give location) 0396 1429 Roanoke	
3. NAME OF DECEASED (Type or print) First Middle Last DELLA M. WITHERSPOON		4. DATE OF DEATH Month Day Year April 9, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 20 APRIL 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Missouri
13a. FATHER'S NAME JOHN WILKINSON		13b. MOTHER'S MAIDEN NAME NETTIE LLOYD	14. NAME OF HUSBAND OR WIFE Divorced
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 Address Norma Lee White (Daughter) Springfield, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arterial Hypertension + Mitral Stenosis DUE TO (c) 10 years			INTERVAL BETWEEN ONSET AND DEATH immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4251			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.)	
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 COUNTY STATE	
21. I attended the deceased from 2-3-1949 to 4/9/59 and last saw her alive on 2-6-59 Death occurred at 11:00 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Degree or title)		22b. ADDRESS Springfield Med. Bldg. Springfield, Missouri	22c. DATE SIGNED 4-10-59
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 4/13/59	23c. NAME OF CEMETERY OR CREMATORY Greenlawn	23d. LOCATION (City, town, or county) (State) Springfield, Mo.
24. FUNERAL DIRECTOR ADDRESS J.W. KLINGNER & CO. SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 4-15-59	26. REGISTRAR'S SIGNATURE <i>Effie E. Melton</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JAN 26 1962

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 *Glen D. Williams*

Licensed Embalmer No. *4651*

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.