

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021028

FILED JUL 7 1959

Registration District No. 128 Primary Registration District No. 2000 STATE FILE NUMBER Registrar's No. 725

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 St. Johns Hospital		Length of stay in 1b # STREET ADDRESS RFD #. 12	
3. NAME OF DECEASED (Type or print) Kitty		4. DATE OF DEATH Month June Day 30 Year 1959	
5. SEX Female	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 12 July 1888
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 M.J. Shetley		13b. MOTHER'S MAIDEN NAME Jennie Whitner	14. NAME OF HUSBAND OR WIFE Clarence
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go on, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Hospital Records
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma sigmoid Colon Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) With pelvic metastasis and Large Bowel obstruction DUE TO (c) 1533			INTERVAL BETWEEN ONSET AND DEATH 4 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Best-operative Transverse Colostomy			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> None <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. None p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 June 15, 1959 to 6/30/59 and last saw her ^{him} alive on 6-30-59 Death occurred at 3:45 P. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W. J. Paul, M.D.		22b. ADDRESS 609 Cherry Springfield, Missouri	22c. DATE SIGNED 7/1/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/2/59	23c. NAME OF CEMETERY OR CREMATORY White Chapel	23d. LOCATION (City, town, or county) (State) Springfield, Mo.
24. FUNERAL DIRECTOR J.W. KLINGNER & CO. Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 7-2-59	26. REGISTRAR'S SIGNATURE Effie S. Melton

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

Max Rude

Licensed Embalmer No. *407*

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.