

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-028793**  
STATE FILE NUMBER

FILED VS. AUG 24 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. 2000 Registrar's No. 866

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>		Length of stay in 1b	c. CITY OR TOWN <b>Springfield</b> 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>2414 1/2 N. Kellett</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2414 1/2 N. Kellett</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>GRUNDY</b> Last <b>WRIGHT</b>			4. DATE OF DEATH Month <b>August</b> Day <b>15</b> Year <b>1959</b>			
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"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>28 Jan. 1884</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (City and state or country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>William Wright</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Thompson</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>493-16-9782</b>		17. INFORMANT Address <b>Marguerite Sater Springfield, Mo.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease ?</b>		<b>Not Known</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Generalized Arteriosclerosis</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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 _____ a.m. _____ p.m. Month, Day, Year _____			

20d. INJURY OCCURRED WHILE AT WORK <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, Missouri</b>	COUNTY _____ STATE _____
21. I attended the deceased from <u>on two occasions 11-8-59 and 12-9-59</u> to <u>8-15-59</u> and last saw him alive on <u>7-2-59</u> Death occurred at <u>6:30</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <b>Albert O. Simpson, M.D.</b> (Degree or title)	22b. ADDRESS <b>307 Spgfd. Medical Building Springfield, Missouri</b>	22c. DATE SIGNED <b>8-18-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8/17/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Mo.</b>

24. FUNERAL DIRECTOR <b>KLINGNER MORTUARY, INC.</b>	ADDRESS <b>Springfield, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>8-18-59</b>	26. REGISTRAR'S SIGNATURE <b>Effie S. Neelon</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Mal F...

Licensed Embalmer No. 407

P. O. Address Spring

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.