

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031971

FILED VS OCT 5 1959

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1004

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>GREENE</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		Length of stay in 1b		c. CITY OR TOWN <u>SPRINGFIELD</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. JOHNS HOSP'</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>730 S. ROGERS</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>ANN</u> Last <u>CARDWELL</u>			4. DATE OF DEATH Month <u>SEPT.</u> Day <u>22</u> Year <u>1959</u>					
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3-10-1880</u>	9. AGE (last birthday) <u>79</u>	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) <u>HOUSE WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>WEBSTER CO. MO</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>JOINER GENTRY</u>			13b. MOTHER'S MAIDEN NAME <u>MARTHA SMITH</u>			14. NAME OF HUSBAND OR WIFE <u>DECEASED</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>MRS. JANNITA BOBBINGER SPFG. MO.</u> Address _____			
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>Coronary Decomposition - failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension - Arterio-sclerotic</u> 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								
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 checked="" 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 <u>2-28-52</u> to <u>9-22-59</u> and last saw her ^{her} _{him} alive on <u>9-21-59</u> Death occurred at <u>11:45 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>John W. [Signature]</u> (Degree or title)				22b. ADDRESS <u>[Address]</u>		22c. DATE SIGNED <u>9-29-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9-25-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SEYMOUR MASONIC CEMETERY</u>		23d. LOCATION (City, town, or county) <u>WEBSTER CO. MO.</u>		(State)		
24. FUNERAL DIRECTOR <u>Robert Bergman</u> Address <u>Seymour, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>9-20-59</u>		26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>			

(Licensed Embalmer's Statement on Reverse Side)

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 Max L. Miller

Licensed Embalmer No. 472

P. O. Address Manlyfield

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.