

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DR. LEMMON FILED VS NOV 9 1959

59-035778

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2002 Registrar's No. 1185

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>GREENE</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u> Length of stay in 1b <u>75 YRS.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1230 E. WALNUT</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u> c. CITY OR TOWN <u>SPRINGFIELD</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1230 E. WALNUT</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>ANTHONY</u> Middle <u>L.</u> Last <u>ARNOLD</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>3</u> Year <u>1959</u>											
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6/21/68</u>		9. AGE (last birthday) <u>91</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>RETIRED CLERK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FEDERAL COURT</u>				11. BIRTHPLACE (City and state or country) <u>COMMERCE, MO.</u>				12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>GEORGE W. ARNOLD</u>				13b. MOTHER'S MAIDEN NAME <u>LOUISA BUISSART</u>				14. NAME OF HUSBAND OR WIFE <u>MARY ARNOLD</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Spanish American</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT Address <u>MARY ARNOLD, SPRINGFIELD, MO.</u>							
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>Arteriosclerosis, gen'd</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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 INTERVAL BETWEEN ONSET AND DEATH <u>Sev. mos.</u>															
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 _____				COUNTY _____ STATE _____							
21. I attended the deceased from <u>Aug. 59</u> to <u>11-3</u> and last saw ^{her} him alive on <u>11-2-59</u> Death occurred at <u>4 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE <u>G.B. Lemmon MD</u> (Degree or title)						22b. ADDRESS <u>Prof Bldg. Spfld, Mo</u>				22c. DATE SIGNED <u>11-4-59</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE <u>11/5/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CEMETERY</u>				23d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD, MO.</u>						
24. FUNERAL DIRECTOR ADDRESS <u>H.H. LOHMEYER SPRINGFIELD, MO.</u>					25. DATE RECD. BY LOCAL REG. <u>11-5-59</u>			26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

RECEIVED NOV 10 1959

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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 *H. L. McCarroll*

Licensed Embalmer No. *2715*

P. O. Address *Springfield, Mo.*

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.