

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 9 4 9

FILED VS. DEC 28 1959 / 28

Registration District No. _____ Primary Registration District No. 2000 Registrar's No. 1383

STATE FILE NUMBER

INDEXED

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	Length of stay in 1b	c. CITY OR TOWN Springfield	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1227 N. Prospect
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First ROBERT Middle Ray Last REESE			4. DATE OF DEATH Month December Day 19 Year 1959		
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5. SEX Male	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 8 July 1890	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transfer Co. Employee		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME C.L. Reese		13b. MOTHER'S MAIDEN NAME (unknown)		14. NAME OF HUSBAND OR WIFE Drumwright Mable Reese
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI	16. SOCIAL SECURITY NO. 491-03-5430	17. INFORMANT Hospital Records
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerosis of brain & heart			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Coronary thrombosis 6 days	DUE TO (c) Chr. Cardiac valve disease ?	
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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	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 Springfield, Missouri	COUNTY _____ STATE _____
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21. I attended the deceased from Dec 14, '59 to 12/19/59 and last saw ^{her} him alive on 12/19/59 Death occurred at 6:20 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE Arthur D. Krabel MO		(Degree or title)	22b. ADDRESS 1630 N. Jefferson Springfield, Missouri	22c. DATE SIGNED 12-21-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/22/59	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemery	23d. LOCATION (City, town, or county) Springfield, Missouri	(State)
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24. FUNERAL DIRECTOR KLINGNER MORTUARY, INC.	ADDRESS SPRINGFIELD MO.	25. DATE RECD. BY LOCAL REG. 12-22-59	26. REGISTRAR'S SIGNATURE Effie G. Melton
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

jhc

DEC 30 19

DEC 28 1959

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 Fle

Licensed Embalmer No. 40

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.

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