RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

60-001025
STATE FILE NUMBER

FILED VS FEB 1 1960 128 Registration District No. 2000 Primary Registration District No. Registrar's No. 98

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Springfield
Length of stay in 1b:
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Burge Hospital
Inside Limits: Yes X No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: Greene
c. CITY OR TOWN: Springfield
Inside Limits: Yes X No ☐
d. STREET ADDRESS (If outside, give location): 500 E. Madison
Reside on Farm: Yes ☐ No X

3. NAME OF DECEASED (Type or print): First JAMES Middle Z. Last CHRISTIAN
4. DATE OF DEATH: Month January Day 23, Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married X Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 5 Oct. 1897
9. AGE (last birthday): 62
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): President of Optical Company
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: I.D. Christian
13b. MOTHER'S MAIDEN NAME: Mossie Acuff
14. NAME OF HUSBAND OR WIFE: Madge Christian
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Hospital Records Address

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)	Hepatic failure	48 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Generalized Peritonitis	7 days
DUE TO (c)	Biliary tract fistula	10 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Duodenal Ulcer (operated)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO X
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 JAN. 10-1959 to 1/23/60 and last saw he/him alive on 1/23/60
Death occurred at 10:45 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Michael J. Clarke M.D.
22b. ADDRESS: 1636 S. Glenstone - Springfield, Missouri
22c. DATE SIGNED: 1-25-60
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 1-25-60
23c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery
23d. LOCATION (City, town, or county) (State): Springfield, Missouri
24. FUNERAL DIRECTOR: KLINGNER MORTUARY, INC. ADDRESS
25. DATE RECD. BY LOCAL REG.: 1-25-60
26. REGISTRAR'S SIGNATURE: Effie E. Meeter

(Licensed Embalmer's Statement on Reverse Side)

MAY 24 1960

FEB 1

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 _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 407

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.