

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001152

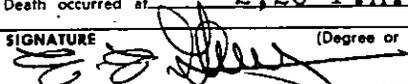
Dr. E. F. Glenn
LED VS JAN 11 1960

128

Primary Registration District No. 2000

Registar's No. 29

STATE FILE NUMBER

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 ST. JOHN'S HOSP.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2926 W. WASHITA		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First BEN Middle A. Last STALLINGS				4. DATE OF DEATH Month JAN. Day 7 Year 1960					
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 7/3/91	9. AGE (last birthday) 68		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - FRUIT MARKET			10b. KIND OF BUSINESS OR INDUSTRY OPERATOR		11. BIRTHPLACE (City and state or country) CHRISTIAN COUNTY, MO.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME AUGUST STALLINGS			13b. MOTHER'S MAIDEN NAME AMANDA TINNES			14. NAME OF HUSBAND OR WIFE HAZEL STALLINGS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 493-16-2475		17. INFORMANT HAZEL STALLINGS,			Address SPRINGFIELD, MO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Failure, Comp. pneumonia							INTERVAL BETWEEN ONSET AND DEATH 24 hrs.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Chronic Emphysema				10 years.			
		DUE TO (c) Bronchial Asthma				15 years.			
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 Month, Day, Year 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		COUNTY		STATE	
21. I attended the deceased from 7-10-44 to 1-7-60 and last saw her alive on 1-7-60 Death occurred at 2:20 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE  (Degree or title)				22b. ADDRESS M.D. 609 Cherry-Springfield, Mo.				22c. DATE SIGNED 1-8-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1/9/60	23c. NAME OF CEMETERY OR CREMATORY EASTLAWN		23d. LOCATION (City, town, or county) SPRINGFIELD, MO.			(State)	
24. FUNERAL DIRECTOR H.H. LOHMEYER,				ADDRESS SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 1-8-1960		26. REGISTRAR'S SIGNATURE 	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 14 1960

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 A. L. McCann

Licensed Embalmer No. 272

P. O. Address Spanghald

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.