

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001157

Wakeman
 FILED VS FEB 1 1960 128
 Primary Registration District No. 2000 Registrar's No. 97 STATE FILE NUMBER

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| 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 lb <u>74 YRS.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>848 SOUTH</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>848 SOUTH</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
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| 3. NAME OF DECEASED (Type or print) First <u>MAUDE</u> Middle <u>MARY</u> Last <u>STONEMAN</u> | | | 4. DATE OF DEATH Month <u>JAN.</u> Day <u>23</u> Year <u>1960</u> | | | | |
| 5. SEX <u>FEMALE</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>11/5/79</u> | 9. AGE (last birthday) <u>80</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>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>ROSCOE, OHIO</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |

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| 13a. FATHER'S NAME <u>GEORGE D. TOLAND</u> | | 13b. MOTHER'S MAIDEN NAME <u>SUSAN STANFORD</u> | | 14. NAME OF HUSBAND OR WIFE <u>ALBERT E. STONEMAN</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>NO</u> | | 17. INFORMANT <u>ALBERT E. STONEMAN, SPRINGFIELD, MO</u> | |

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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) <u>Myocarditis, Chronic</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Arteriosclerotic Heart Disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>3-4 years</u> |
| 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 |

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| 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"/> | |

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| 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>1957</u> to <u>1-23-60</u> and last saw ^{him} _{her} alive on <u>1-23-60</u> Death occurred at <u>1:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |

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| 22a. SIGNATURE (Degree or title) <u>J. Newton Walkeman M.D.</u> | | 22b. ADDRESS <u>Springfield, Mo</u> | | 22c. DATE SIGNED <u>1-25-60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>1/27/60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL</u> | 23d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD, MO.</u> | |

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| 24. FUNERAL DIRECTOR ADDRESS <u>H. H. LOHMEYER, SPRINGFIELD, MO.</u> | 25. DATE RECD. BY LOCAL REG. <u>1-26-60</u> | 26. REGISTRAR'S SIGNATURE <u>Effie S. Meeton</u> |
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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 *A. J. McCann*

Licensed Embalmer No. 272

P. O. Address *Springfield*

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.