

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014934

FILED VS. APR. 25 1960 / 28 Primary Registration District No. 2000 Registrar's No. 437

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Length of stay in 1b <b>7 YRS.</b>	c. CITY OR TOWN <b>SPRINGFIELD</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. BURGE HOSP.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1413 E. LOCUST</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>SOULE</b> Last			4. DATE OF DEATH Month <b>APRIL</b> Day <b>15</b> Year <b>1960</b>			
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/25/52</b>	9. AGE (last birthday) <b>7</b>	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) <b>STUDENT</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>SPRINGFIELD, MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>VICTOR H. SOULE</b>	13b. MOTHER'S MAIDEN NAME <b>CATHERINE JONES</b>	14. NAME OF HUSBAND OR WIFE <b>X</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT Address <b>VICTOR H. SOULE, SPRINGFIELD, MO.</b>
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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) <b>Suffocation</b> <b>compression of the neck</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b>
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>he was playing in an old military tank when apparently his neck was caught between the guns breech block and the top of the turret. There were other boys playing nearby.</b>
20c. TIME OF DEATH Hour <b>2:30 P.M.</b> a.m. Month, Day, Year <b>4/15/60</b>	20d. INJURY OCCURRED <b>NOT WHILE AT WORK</b>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>on Nat'l Guard Reserv.</b>
20f. CITY, TOWN, OR LOCATION <b>Springfield, Greene, Missouri</b>		COUNTY STATE

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at **approx. 2:45 P.M.** \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Paul H. Soule</i> (Degree or title) <b>Greene County Coroner</b>	22b. ADDRESS <b>Springfield, Missouri</b>	22c. DATE SIGNED <b>4/18/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>4/18/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREENLAWN</b>	23d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD, MO.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>H.H. LOHMEYER, SPRINGFIELD, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>4-19-60</b>	26. REGISTRAR'S SIGNATURE <i>Effie B. Melton</i>
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(Licensed Embalmer's Statement on Reverse Side)

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 H. L. McC. Connor

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.