

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-026540

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128

Registration District No. 2000

Registrar's No. 810

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 lb 2 HRS.	c. CITY OR TOWN BROOKLINE Inside Limits Yes <input type="checkbox"/> No <input checked="" 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) ROUTE # 1 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First	Middle	Last	Month	Day	Year	
SIMON RAPER			JULY 26 1960			

5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/3/90	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	10b. KIND OF BUSINESS OR INDUSTRY FARMER	11. BIRTHPLACE (City and state or country) GEORGIA	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME BENJAMIN H. RAPER	13b. MOTHER'S MAIDEN NAME VINA LITTLE	14. NAME OF HUSBAND OR WIFE
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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 W.W. # I	16. SOCIAL SECURITY NO. 491-44-1747	17. INFORMANT Address WILLIAM RAPER, BROOKLINE, MO.
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)		12 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
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

Acute myocardial infarction

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.	Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
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21. I attended the deceased from **26 July 1960** to **26 July 1960** and last saw him alive on **26 July 1960**
 Death occurred at **6:15 P.M.** on the date stated above, and to the best of my knowledge from the causes stated.

22a. SIGNATURE <i>Francis M. Maple MD</i>	(Degree or title)	22b. ADDRESS <i>Springfield, Mo</i>	22c. DATE SIGNED <i>29 July 1960</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 7/29/60	23c. NAME OF CEMETERY OR CREMATORY NATIONAL	23d. LOCATION (City, town, or county) SPRINGFIELD, MO.
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24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 7-28-60	26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 1 1960

AUG 3 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 _____, Student Embalmer No. _____, or by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W. L. McCann

Licensed Embalmer No. 2727

P. O. Address Springfield

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