

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-026549

FILED VS JUL 18 1960

128

2000

759

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		c. CITY OR TOWN Springfield	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital		d. STREET ADDRESS (If outside, give location) 1602 N Main	
3. NAME OF DECEASED (Type or print) First Jessie Middle F. Last Slavens		4. DATE OF DEATH Month July Day 11, Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5 March 1875
9. AGE (last birthday) 85		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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Michigan
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Frank Graham	
13b. MOTHER'S MAIDEN NAME Mary Huggins		14. NAME OF HUSBAND OR WIFE Deceased	
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. Unknown	17. INFORMANT Mrs. Deward Spalding (Niece) Address Oklahoma City, Okla.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-renal.			INTERVAL BETWEEN ONSET AND DEATH Don't know
DUE TO (b) Uremia			6 days
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"/> N. <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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"/>	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 7,5,1960 to 7/11/60 and last saw her ^{her} last alive on 7/11/60 Death occurred at 8:04 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>J. J. [Signature]</i> (Degree or title)		22b. ADDRESS Springfield, Missouri	22c. DATE SIGNED 7-12-60
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 7/13/60	23c. NAME OF CEMETERY OR CREMATORY Urbana Cemetery	23d. LOCATION (City, town, or county) (State) Urbana, Mo.
24. FUNERAL DIRECTOR Klingner Mortuary ADDRESS Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 7-14-60	26. REGISTRAR'S SIGNATURE <i>Effie B. Melton</i>

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 J. B. Klempner

Licensed Embalmer No. 3350

P. O. Address _____

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.