

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041611

FILED VS DEC 5 1960

Registration District No. 128 Primary Registration District No. 2002 Registrar's No. 1199

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b		c. CITY OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1329 Concord</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Melvina</u> Middle <u>Bockhorst</u> Last <u>Bockhorst</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>1</u> Year <u>1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-1900</u>	9. AGE (last birthday) <u>60</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Nurse</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Day Nursery</u>		11. BIRTHPLACE (City and state or country) <u>Oregon Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13a. FATHER'S NAME <u>John Walker</u>			13b. MOTHER'S MAIDEN NAME <u>Lettie Williams</u>			14. NAME OF HUSBAND OR WIFE <u>deceased</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no name</u>			16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs. J. H. Bockhorst, Jr.,</u>			Address <u>Springfield, Mo.</u>
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) <u>Hepatic failure</u>								
DUE TO (b) <u>Hepatic metastases</u>							<u>4 mo.</u>	
DUE TO (c) <u>Metastatic adenocarcinoma of colon</u>							<u>1 yr.</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 checked="" 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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		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
21. I attended the deceased from <u>10-24-59</u> to <u>12-1-60</u> and last saw her <sup>her</sup> <del>live</del> <sup>alive</sup> on <u>12-1-60</u> Death occurred at <u>5:20 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>F. Edward Moseley M.D.</u> (Degree or title)				22b. ADDRESS <u>1636 S. Glenstone, Springfield, Missouri</u>			22c. DATE SIGNED <u>12/2/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-3-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>East Lawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>				
24. FUNERAL DIRECTOR <u>Rea Rainey, Springfield, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>12-2-60</u>		26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 9 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 Joe Mason

Licensed Embalmer No. 456

P. O. Address Spring

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