

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Dr. Turner
AMENDED

Registration District No. 128

Primary Registration District No. 200

Registrar's No. 265A

STATE FILE NUMBER

61-008434

FILED MAR 27 1961

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 <u>88 YRS.</u>		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>ST. JOHN'S HOSP.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>917 E. PAGE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>NEVA</u> Middle <u>SCHOLTEN</u> Last <u>SCHOLTEN</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>14</u> Year <u>1961</u>										
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3/24/72</u>		9. AGE (last birthday) <u>88</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>RETIRED SCHOOL TEACHER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>TEACHER</u>		11. BIRTHPLACE (City and state or country) <u>SPRINGFIELD, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>CHARLES SCHOLTEN</u>				13b. MOTHER'S MAIDEN NAME <u>CLARA ROUNTREE</u>				14. NAME OF HUSBAND OR WIFE <u>X</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 Address <u>MARY MOORE, SPRINGFIELD, MO.</u>							
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>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>SEVERAL YEARS.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>RENAL CELL CARCINOMA OF THE KIDNEY.</u>										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 checked="" 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 <u>8/6/56</u> to <u>3/14/61</u> and last saw ^{her} <u>him</u> alive on <u>3/14/61</u> . Death occurred at <u>4 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Glenn O. Turner, M.D.</u>						22b. ADDRESS <u>Springfield, Mo.</u>				22c. DATE SIGNED <u>3/18/61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>3/16/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S</u>		23d. LOCATION (City, town, or county) <u>SPRINGFIELD, MO.</u>							
24. FUNERAL DIRECTOR ADDRESS <u>H. H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.</u>				25. DATE RECD. BY LOCAL REG. <u>3-20-61</u>		26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>							

DATE AMENDED

 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

 INSTead OF

 DOCUMENT

 MEDICAL CERTIFICATION

 SHOULD READ

 BY AFFIDAVIT OF

APR 14 1961

MAR 27 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed APL McCann

Licensed Embalmer No. 2727

P. O. Address Applied mo

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.