

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-020936

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Dr. JOE L. AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 584

STATE FILE NUMBER

FILED JUN 19 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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) SPRINGFIELD		Length of stay in lb 25 YRS.	c. CITY OR TOWN SPRINGFIELD Inside Limits Yes <input checked="" type="checkbox"/> No <input 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) 535 ILDEREEN Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GENEVIEVE Middle M. Last DELANCEY		4. DATE OF DEATH Month JUNE Day 13 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/24/92
9. AGE (last birthday) 68		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	11. BIRTHPLACE (City and state or country) OMAHA, NEB.
11. BIRTHPLACE (City and state or country) OMAHA, NEB.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME JAMES DENT		13b. MOTHER'S MAIDEN NAME ANNA CONLON	14. NAME OF HUSBAND OR WIFE ROBERT L. DELANCEY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NO	17. INFORMANT Address ROBERT L. DELANCEY, SPRINGFIELD, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident			INTERVAL BETWEEN ONSET AND DEATH 4 wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) old CVA			16 yrs
DUE TO (c) Arteriosclerosis			years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) URINARY INFECTION		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	
PART III. If deceased was female was there a pregnancy in last 90 days. STAB HORN STONES OF KIDNEYS		<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 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 5-14-61 to 6-13-61 and last saw her/him alive on 6-13-61 Death occurred at 3:45 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Louis E. Joul, MD		22b. ADDRESS 1636 So. Blainstone	22c. DATE SIGNED 6-14-61
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 6/17/61	23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI
24. FUNERAL DIRECTOR ADDRESS H. H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 6-16-61	26. REGISTRAR'S SIGNATURE Effie E. Patton

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 W. McCann

Licensed Embalmer No. 2727

P. O. Address W. McCann

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.