

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-020951

STATE FILE NUMBER

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 629

FILED JUL 10 1961

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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) OR TOWN Springfield		Length of stay in lb		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 916 South Avenue			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 916 South Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JOSEPH Middle HENRY Last FOX			4. DATE OF DEATH Month June Day 29 Year 1961						
5. SEX Male	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 8 April 1887	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME William A. Fox			13b. MOTHER'S MAIDEN NAME Ruth Caskey			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) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> WW1				17. INFORMANT Address Byrda Wilson (Sister) 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) Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Dis. DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 8 months years		
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			
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 <u>6-13-61</u> to <u>6/29/61</u> and last saw him alive on <u>6-25-61</u> Death occurred at <u>1:30</u> a <u> </u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>W. D. Hanson</i> (Degree or title) M.D.				22b. ADDRESS 600 S. Glenstone Springfield, Missouri				22c. DATE SIGNED 7-3-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-1-61	23c. NAME OF CEMETERY OR CREMATORY Danforth Cemetery		23d. LOCATION (City, town, or county) (State) Greene County, Missouri				

24. FUNERAL DIRECTOR ADDRESS **KLINGNER MORTUARY, INC. Springfield, Mo.** 25. DATE RECD. BY LOCAL REG. **7-5-61** 26. REGISTRAR'S SIGNATURE *Effie E. Melton*

jhc

(Licensed Embalmer's Statement on Reverse Side)

JUL 10 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 Catherine Flanagan

Licensed Embalmer No. 2719

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.