

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044226
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1294

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

FILED JAN 2 1962

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 1b 55 Years c. CITY OR TOWN Springfield Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital Inside Limits Yes No d. STREET ADDRESS (If outside, give location) 620 N. Grant Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year
CALLIE DONA DIUGUID December 20, 1961

5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH April 29, 1881 9. AGE (last birthday) 80 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) House wife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (City and state or country) Virginia 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Robert Watkins 13b. MOTHER'S MAIDEN NAME Mary Strong 14. NAME OF HUSBAND OR WIFE --

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 Self - By pre-arrangement Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease - Decomposed 3 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis
DUE TO (c) Cerebral Hemorrhage 6 wks.

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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 9-16-61 to 12-20-61 and last saw her live on 12-19-61
Death occurred at 2:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [Signature] 22b. ADDRESS Springfield, Mo. 22c. DATE SIGNED 12-21-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE Dec 22, 1961 23c. NAME OF CEMETERY OR CREMATORY Greenlawn 23d. LOCATION (City, town, or county) (State) Springfield, Mo.

24. FUNERAL DIRECTOR ADDRESS Jewell E. Windle, Springfield, Mo. 25. DATE RECD. BY LOCAL REG. 12-29-61 26. REGISTRAR'S SIGNATURE [Signature]

JAN 2 1962

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 *[Handwritten Signature]*

Licensed Embalmer No. 27277

P. O. Address *[Handwritten 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.