

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-027611

STATE FILE NUMBER

Registration District No. 68 Primary Registration District No. 5266 Registrar's No. 47

FILED AUG 7 1963

| | | | | | |
|---|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Christian b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ozark Length of stay in 1b 3 months c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bilyeu's Nursing Home Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene, c. CITY OR TOWN Springfield Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) Route 3 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First GUY Middle E. Last CLEVENGER | | | 4. DATE OF DEATH Month July Day 30, Year 1963 | | |
| 5. SEX Male | 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 August 2, 1890 | 9. AGE (last birthday) 72 | IF UNDER 1 YEAR Months 11 Days 28 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee | | 10b. KIND OF BUSINESS OR INDUSTRY Lime and Cement Co., Tennessee | | 11. BIRTHPLACE (City and state or country) USA | |
| 13a. FATHER'S NAME Robert Clevenger | | | 13b. MOTHER'S MAIDEN NAME Laura | | 14. NAME OF HUSBAND OR WIFE Metta Clevenger |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mrs. Metta Clevenger Springfield, Mo. |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medullary Paralysis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage DUE TO (c) Arteriosclerosis | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 days 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>7/25/63</u> to <u>7/28/63</u> and last saw her/him alive on <u>7/28/63</u> Death occurred at _____ 10 P.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <i>Wm. M. Bernard, D.O.</i> | | | 22b. ADDRESS Ozark, Mo. | | 22c. DATE SIGNED 8/1/63 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE August 2, 1963 | 23c. NAME OF CEMETERY OR CREMATORY Galloway | | 23d. LOCATION (City, town, or county) (State) Galloway, Missouri |
| 24. FUNERAL DIRECTOR ADDRESS Gorman-Scharpf Funeral Home, Inc. Springfield, Missouri | | | 25. DATE RECD. BY LOCAL REG. Aug. 5, 1963 | 26. REGISTRAR'S SIGNATURE <i>Mary Kaufman</i> | |

DO NOT WRITE ON THIS STUB
 AMENDED
 DATE AMENDED
 1 0720
 2 0390
 3
 4 0
 5 1
 6
 7 1
 8 2
 9 331X
 10
 11
 12 86-2
 13 1-0
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF
 ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

AUG 8 1963

AUG 16 1963

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 Lewis D. Schaefer

Licensed Embalmer No. 3802

P. O. Address Springfield, 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.

0 5 5 0 1 3

20-5

Permit obtained July 30, 1963. M.F.

imposed upon the body of the deceased...
The body of the deceased...
The body of the deceased...
The body of the deceased...