

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-027917

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1139

FILED JUL 22 1963

DO NOT WRITE ON THIS STUB

AMENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Greene</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b> Length of stay in 1b <b>8 years</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b> c. CITY OR TOWN <b>Springfield</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>2132 South Stewart</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>Burge Prot. Hospital</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

<b>3. NAME OF DECEASED</b> (Type or print) First <b>MYRTLE</b> Middle <b>IRENE</b> Last <b>EARNHEART</b>			<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>12</b> Year <b>1963</b>		
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>11-14-83</b>	<b>9. AGE (last birthday)</b> <b>79</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Homemaker</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Batesville, Ark.</b>	
<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>					

<b>13a. FATHER'S NAME</b> <b>Unknown--Montgomery</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Deceased Joseph W. Earnheart, Springfield, MO.</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of serv) <b>No None</b>			<b>17. INFORMANT</b> <b>Ross W. Earnheart, 2132 S. Stewart, Batesville, Ark.</b>		

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cor pulmonale</b> DUE TO (c) <b>Chronic emphysema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b> <b> yrs</b> <b> yrs</b>
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

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)		
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____				

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	COUNTY	STATE
<b>21. I attended the deceased from</b> <u>11-23-57</u> <b>to</b> <u>7-12-63</u> <b>and last saw</b> <sup>her</sup> <b>him</b> <b>alive on</b> <u>7-12-63</u> Death occurred at <u>11:30 A.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

<b>22a. SIGNATURE</b> (Degree or title) <i>W Yates Trotter M.D.</i>	<b>22b. ADDRESS</b> <b>609 Cherry-Springfield, Mo.</b>	<b>22c. DATE SIGNED</b> <b>7-15-63</b>
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<b>23a. BURIAL, CREMATION REMOVAL (Specify)</b> <b>Removal</b>	<b>23b. DATE</b> <b>7-12-1963</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Bethesda</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>Independance Co., Ark.</b>
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>A. L. Crouch, Batesville, Ark.</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>7-12-63</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Effie E. Melton</i>

VS 300 Rev. 4/59	DATE AMENDED								
1 <u>0397</u>									
2 <u>0397</u>									
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4 <u>1</u>									
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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

JUL 23 1963

MAY 17 1964

permits 1-12-63

**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 *Nicholas L. Strassner*

Licensed Embalmer No. *5164*  
P. O. Address *Spfld, 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.