

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-027974**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2.000 Registrar's No. 1169

**FILED JUL 31 1963**

1. PLACE OF DEATH a. COUNTY <b>Greene</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Greene</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Length of stay in 1b <b>33 yrs</b>		c. CITY OR TOWN <b>Springfield</b> Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Burge Protestant Hospital</b>			d. STREET ADDRESS <b>1145 Cheery</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Earl Lee Pool</b>			4. DATE OF DEATH Month Day Year <b>July 22 1963</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1892</b>	9. AGE (last birthday) <b>71</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Produce business</b>		11. BIRTHPLACE (City and state or country) <b>Waverly Ill.</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>John H. Pool</b>		13b. MOTHER'S MAIDEN NAME <b>Mary M. Phipps</b>	
14. NAME OF HUSBAND OR WIFE <b>Dorothy M. Pool</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>441-38-1111</b>	
17. INFORMANT <b>Mrs. Dorothy M. Pool</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>Right hemiplegia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Right hemiplegia</b> DUE TO (c) _____ 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		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
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 checked="" 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 <b>1952</b> to <b>July 22, 1963</b> and last saw <sup>her</sup> him alive on <b>July 21, 1963</b> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>A. Stans</b> (Degree or title) <b>M.D.</b>		22b. ADDRESS <b>Springfield, Mo.</b>		22c. DATE SIGNED <b>7-23-63</b> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7-25-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		23d. LOCATION (City, town, or county) <b>Springfield, Missouri</b> (State)	
24. FUNERAL DIRECTOR <b>Gorman-Scharpf Funeral Home</b> ADDRESS <b>Springfield, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>7-29-63</b>		26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

Dr  
Hanss  
600

AUG 1 1963

7-23-63

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 L. Deakin Gorman

Licensed Embalmer No. 3177

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.

RECEIVED  
DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
SPRINGFIELD, MISSOURI