

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-035849
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 5465 Registrar's No. 1255

FILED SEP 19 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>2nd N. Campbell, Twsp.</u> Length of stay in 1b		c. CITY OR TOWN <u>2nd N. Campbell, Twsp.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R.F.D. #11</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RFD #11</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Flora</u> Middle <u>Witherspoon</u> Last			4. DATE OF DEATH Month <u>September</u> Day <u>6</u> Year <u>1963</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/28/1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE (last birthday) <u>90</u>
13a. FATHER'S NAME <u>James Beaman</u>		13b. MOTHER'S MAIDEN NAME <u>Woodward</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
DUE TO (c)		1 year	
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 <u>1:00</u> a.m. p.m.	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.)
21. I attended the deceased from <u>3/6/51</u> to <u>9/6/63</u> and last saw her <u>alive</u> on <u>9/4/1963</u> Death occurred at <u>1:00</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Springfield, Missouri</u>	
22a. SIGNATURE (Degree or title) <u>Dr. Lockhart M.D.</u>		22b. ADDRESS <u>Springfield, Missouri</u>	22c. DATE SIGNED <u>9/10/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>9/9/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bellview Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Greene Co. Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Klingner Mortuary, Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-17-63</u>	26. REGISTRAR'S SIGNATURE <u>Gerrine Medley</u>

USE BLACK INK
OR
TYPEWRITER RIBBON

STATE

OVER
SEEN
C O

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 Glenn D Williams

Licensed Embalmer No. 4651

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.