Health, Welfare [Pu]blic Service

9 Dr. McALHANY

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-009048
STATE FILE NUMBER

[FI]LED APR 14 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 355

[..]. 300
1-57

1. PLACE OF DEATH a. COUNTY GREENE	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY BERRY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) SPRINGFIELD — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN WAYNE 0650 — Inside Limits Yes [ ] No [X]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. JOHN'S HOSP. — Length of stay in 1b 2 DAYS	d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First JERRY Middle DEAN Last ERWIN	4. DATE OF DEATH Month APRIL Day 3 Year 1959
5. SEX MALE	6. COLOR OR RACE WHITE
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH JUNE 4 1942
9. AGE (In years last birthday) 16	IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) WAYNE, MISSOURI	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME JAYHUGH W. ERWIN	13b. MOTHER'S MAIDEN NAME DOROTHY MARTIN
14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. NO
17. INFORMANT JAYHUGH ERWIN	Address WASHBURN, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Malacia of mesencephalon & pons	3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Thrombosis of basilar artery	4 days
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [X] 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 4/1/59, to 4/3/59 and last saw him alive on 4/3/59
Death occurred at 1:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H. J. McAlhany, M.D. 22b. ADDRESS Springfield, Mo. 22c. DATE SIGNED 4/4/59

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
BURIAL	4/8/59	MAPLE WOOD	EXETER, MISSOURI

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
H.H. LOHMEYER	SPRINGFIELD, MO.	4-6-59	Effie O. Melton

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

Box 134 R
5, 55.

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 .... Signed H L McCann
Signature of Student Embalmer

Licensed Embalmer No. 2727

P. O. Address Springfield Ne

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.