

Dr. Horton

FILED SEP 17 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26597

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 816

300  
1-56

No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Springfield</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Burge Hosp.</b>		Length of stay in 1b <b>13 years</b>	d. STREET ADDRESS <b>1519 W. Phelps</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Etta</b> Middle <b>---</b> Last <b>Moore</b>			4. DATE OF DEATH <b>Sept. 7-1956</b> Month <b>Sept.</b> Day <b>7</b> Year <b>1956</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 31-'76</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (In years last birthday) <b>80</b> IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
11. BIRTHPLACE (City and state or country) <b>Lawrence County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Cassity</b>		14. MOTHER'S MAIDEN NAME <b>Belle Henshaw</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. T. L. Wainright-Springfield, Mo.</b> Address
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>Stroke</b>			INTERVAL BETWEEN ONSET AND DEATH <b>20 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Fracture, comminuted, displaced, inter-trochanteric, left femur.</b>			DUE TO (c) <b>9040</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>21</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <b>Fall, 4:00 Am. Bathroom at home</b>	
20c. TIME OF INJURY Hour <b>4:00</b> a.m. <b>9/6/56</b> Month <b>9</b> Day <b>6</b> Year <b>56</b>		20d. INJURY OCCURRED: WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e. g., is or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. CITY, TOWN, OR LOCATION <b>Springfield, Greene, Mo.</b>	
21. I attended the deceased from <b>9/6/56</b> to <b>9/7/56</b> and last saw her alive on <b>9/7/56</b> Death occurred at <b>6:30 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>Amos D. Horton M.D.</b>	
22b. ADDRESS <b>Springfield, Mo.</b>		22c. DATE SIGNED <b>9/8/56</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9-9-1956</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) <b>Lawrence County, Mo.</b>
24. FUNERAL DIRECTOR <b>James Springfield, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>9-11-56</b>	26. REGISTRAR'S SIGNATURE <b>Edith Williamson</b>

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  .....

Licensed Embalmer No. 3312

P. O. Address Springfield

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.