

FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28015

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 804-B

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Springfield TOWN		c. CITY Springfield OR TOWN	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1021 N. Clay		d. STREET ADDRESS 1021 N. Clay	
Length of stay in hospital 13 yrs.		Reside on Farm <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
3. NAME OF DECEASED (Type or print) First PHEBA Middle A. Last HALFORD		4. DATE OF DEATH Month Aug. Day 10 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 31, 1868
9. AGE (In years last birthday) 88		10. IF UNDER 1 YEAR Months 8 Days 3 Hours 9 Min. 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (City and state or country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Overracker		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Bert Thornton		Address Springfield, Mo.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Apoplexy Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 334X			INTERVAL BETWEEN ONSET AND DEATH
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 8:30 a. m. 11 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.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from May 6, 1957 to Aug. 10, 1957 and last saw her alive on May 21, 1957 Death occurred at 8:30 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Lyman D. Brown M.D.		22b. ADDRESS 311 1/2 College	
22c. DATE SIGNED 8/20/57			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Aug. 14, 1957	23c. NAME OF CEMETERY OR CREMATORY Trail Cemetery	23d. LOCATION (City, town, or county) (State) Ozark Cty. Mo.
24. FUNERAL DIRECTOR Ralph Thieme		25. DATE RECD. BY LOCAL REG. 8-21-57	
ADDRESS Springfield, Mo.		26. REGISTRAR'S SIGNATURE Earl Williams	

(Licensed Embalmer's Statement on Reverse Side)

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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

Lee Mason

Licensed Embalmer No.4

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.