

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

29437
State File No. _____
Registrar's No. 767

FILED SEP 20 1948

Registration District No. 128

Primary Registration District No. 2000

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

926

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Springfield Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 minutes
Same (Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield 1
(If outside city or town limits, write "RURAL") 5

(d) Street No. Parents: 1324 Catalpa
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

3. (a) PRINT FULL NAME Infant daughter, Mr & Mrs A Brengle

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 14
year 1948 hour 12 minute 50 P.M.

21. I hereby certify that I attended the deceased from Sept 14, 1948 to Sept 14, 1948
that I last saw her alive on Sept 14, 1948; and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased September 14 1948
(Month) (Day) (Year)

Immediate cause of death Asphyxia Respiratory insufficiency Duration 20 minutes

Due to Asphyxia Respiratory insufficiency

Due to Swind

8. AGE: Years _____ Months _____ Days _____ If less than one day hr. 20 min.

Other conditions Acute Bronchitis
(Include pregnancy within 3 months of death)

9. Birthplace Springfield Missouri
(City, town, or county) (State or foreign country)

Major findings: None

Of operations None

Of autopsy None 160c

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation None

11. Industry or business Infant

12. Name Arthur Brengle

13. Birthplace Flippin Arkansas
(City, town, or county) (State or foreign country)

14. Maiden name Ruth Jarboe

15. Birthplace Quinter Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Arthur Brengle (father)

(b) Address 1324 Catalpa

17. (a) Burial (b) Date thereof 9-16-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 9-16-48 (b) W E Landley MD
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature [Signature] (Specify type of place) _____ (e) Means of injury 0

Address Springfield, Mo Date signed 9-15-48

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.....
....., Registered Apprentice No.
working under my personal supervision.

Signed

Julian R. Loach

Licensed Embalmer No. *16562*

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 this body is not embalmed, fact should be so stated above.