

FILED MAR 12 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4425

396

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 208

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, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	
c. LENGTH OF STAY (in this place)		03/6	
d. FULL NAME OF HOSPITAL OR INSTITUTION 625 E. Pacific		d. STREET ADDRESS (If rural, give location) 625 E. Pacific	

3. NAME OF DECEASED (Type or Print) a. (First) Sarena b. (Middle) C. c. (Last) Bynum			4. DATE OF DEATH (Month) (Day) (Year) March 8 1951		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH March 9 1858		9. AGE (In years last birthday) 93		IF UNDER 1 YEAR Months Days IF UNDER 12 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY In Home		11. BIRTHPLACE (State or foreign country) Tenn.	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME John Shipley		13b. MOTHER'S MAIDEN NAME Jane Varner	
14. NAME OF HUSBAND OR WIFE Deceased		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Dora Van Sandt		ADDRESS Springfield			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 4 days	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)		331X	
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **3-5**, 1951, to **3-8**, 1951, that I last saw the deceased alive on **3-7**, 1951, and that death occurred at **8:30 p** m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>		23b. ADDRESS Springfield, Mo.		23c. DATE SIGNED 3-9-51	
24a. BURIAL CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-11-51		24c. NAME OF CEMETERY OR CREMATORY Maple Park Cemetery	
24d. LOCATION (City, town, or county) (State) Springfield, Mo.					

DATE REC'D BY LOCAL REG. 3-10-51		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE J. W. Klingner & Co.	
				ADDRESS Springfield	

(Licensed Embalmer's Statement on Reverse Side)

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

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
Student Embalmer

Signed Max Rhodes

Licensed Embalmer No. 4071

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