

FILED FEB 1 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 879

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 98

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) Springfield		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN Springfield
d. FULL NAME OF HOSPITAL OR INSTITUTION Burger-Connelly Rest Home		e. STREET ADDRESS (If rural, give location) 2101 N. Grant	4. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or Print)	a. (First) MINERVA	b. (Middle) JANE	c. (Last) BROADSTON	4. DATE OF DEATH (Month) (Day) (Year) January 25 1954
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 4 March 1877	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 6 WKS. Hours _____ Min. _____
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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 (City and State or Foreign Country) / Kansas	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John White	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Deceased
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Bernard Bossi Springfield, Mo.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN SET AND DEATH 7-10
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia (Chronic not determined)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 576X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **3-29**, 19**53**, to **1-25**, 19**54**, that I last saw the deceased alive on **1-20**, 19**54**, and that death occurred at **8:05P** m., from the causes and of the date stated above.

23a. SIGNATURE (Type or Print) [Signature]	(In type or title) MD	23b. ADDRESS Springfield Mo	23c. DATE SIGNED 1-26-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-27-54	24c. NAME OF CEMETERY OR CREMATORY Eastlawn Cemetery	24d. LOCATION (City, town, or county) (State) Springfield Missouri
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DATE REC'D BY LOCAL REG. 1-28-54	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.W. KLINGNER & CO. Springfield, Mo.
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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.....
Signature of Student Embalmer

Signed.....
Max Rhodes

Licensed Embalmer No.
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.