

FILED JAN 18 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

881

State File No.

128

2000

Registrar's No. 23-C

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Breene	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Willard, Rural	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) R # 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) JEFF b. (Middle) DAVIS c. (Last) BROOKS			4. DATE OF DEATH (Month) (Day) (Year) January 6 - 1954		
5. SEX Male	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Dec 5 - 1878		9. AGE (In years last birthday) 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Springfield, Missouri	
12. CITIZEN OF WHAT COUNTRY U.S.A.					

13a. FATHER'S NAME Dave Brooks		13b. MOTHER'S MAIDEN NAME Martha Raine		14. NAME OF HUSBAND OR WIFE Rose B. Brooks	
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. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Tom Brooks R1 Willard, Mo.	

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion, acute			INTERVAL BETWEEN ONSET AND DEATH few min	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetes mellitus				
		DUE TO (c)				
		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		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 **March 1953** to **1-6**, 19**54**, that I last saw the deceased alive on **1-6**, 19**54**, and that death occurred at **11:25 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE G. S. Lemmon, M.D. (Degree or title)		23b. ADDRESS Springfield, Mo		23c. DATE SIGNED 1-6-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Jan 8 - 1954		24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
		24d. LOCATION (City, town, or county) (State) Willard - Mo.			

DATE REC'D BY LOCAL REG. 1-11-54		REGISTRAR'S SIGNATURE Edith Williamson		25. JUDICIAL DIRECTOR'S SIGNATURE ADDRESS Brin - Daniel - Walnut Prooz - Mo.	
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(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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.