

FILED MAY 17 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15498**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2007** Registrar's No. **469**

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. LENGTH OF STAY (In this place)  
**2 HOURS**

c. CITY OR TOWN **Springfield**

d. Is Residence within limits of a city or incorporated town?  
Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION: **Burge Hospital**

e. STREET ADDRESS (If rural, give location)  
**1730 N. Clay** **0396**

3. NAME OF DECEASED  
a. (First) **CLARA**  
b. (Middle) \_\_\_\_\_  
c. (Last) **BROWN**

4. DATE OF DEATH (Month) (Day) (Year)  
**May 12, 1954**

5. SEX **Female**

6. COLOR OR RACE **White**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)  
**Widowed**

8. DATE OF BIRTH **8 October 1875**

9. AGE (In years last birthday) **78**

IF UNDER 1 YEAR Months \_\_\_\_\_ Days \_\_\_\_\_  
IF UNDER 4 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 (City and State or Foreign Country) /  
**Kentucky**

12. CITIZEN OF WHAT COUNTRY?  
**USA**

13a. FATHER'S NAME  
**Unknown**

13b. MOTHER'S MAIDEN NAME  
**Unknown**

14. NAME OF HUSBAND OR WIFE  
**Deceased**

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  
**HOSPITAL RECORDS**

18. CAUSE OF DEATH  
Enter only one cause per line for (a), (b), and (c)  
**MEDICAL CERTIFICATION**  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) **PNEUMONIA, LEFT**  
INTERVAL BETWEEN ONSET AND DEATH **1 wk**  
\*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.  
ANTECEDENT CAUSES  
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (b) **ARTERIOSCLEROTIC heart Disease**  
DUE TO (c) \_\_\_\_\_  
II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.  
**4200**

19a. DATE OF OPERATION  
**None**

19b. MAJOR FINDINGS OF OPERATION  
**None**

20. AUTOPSY?  
YES  NO

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) \_\_\_\_\_ m.

21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **March, 1954**, to **May, 1954**, that I last saw the deceased alive on **May 12, 1954**, and that death occurred at **3:40A m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)  
**William T. Johnson, M.D.**

23b. ADDRESS  
**Springfield, Mo.**

23c. DATE SIGNED  
**May 15, 1954**

24a. BURIAL, CREMATION, REMOVAL (Specify)  
**Burial**

24b. DATE  
**5-15-54**

24c. NAME OF CEMETERY OR CREMATORY  
**GREENLAWN CEME.**

24d. LOCATION (City, town, or county) (State)  
**SPRINGFIELD, MO.**

DATE REC'D BY LOCAL REG. **5-15-54** REGISTRAR'S SIGNATURE  
**Edith Williams**

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS  
**J.W. KLINGNER & CO. Springfield, Mo.**

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: *J. B. Lingner*.....  
Licensed Embalmer No. 330

P. O. Address .....

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.