

FILED NOV 1 - 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **33653**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 989

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>SPRINGFIELD</b>		c. CITY OR TOWN <b>SPRINGFIELD</b>	d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>7 MONTHS</b>		e. STREET ADDRESS (If rural, give location) <b>1221 W. THOMAN</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>MERCY INF.</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>BERTHA</b> b. (Middle) _____ c. (Last) <b>WHITEHEAD</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>OCT. 24, 1954</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>JAN. 8, 1873</b>
9. AGE (In years last birthday) <b>81</b>		# UNDER 1 YEAR Months _____ Days _____	# UNDER 2 WKS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>IN HOME</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>GERMANY</b>
		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>GEORGE MANG.</b>		13b. MOTHER'S MAIDEN NAME <b>ANNA BRIEGEL</b>		14. NAME OF HUSBAND OR WIFE <b>WIDOWED</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO.</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>CARL MANG SPRINGFIELD, MO.</b>	

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 ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic myocarditis</b>		<b>6 mo</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arterio sclerotic Heart Disease</b>		<b>12 mo</b>
DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS <b>Fracture intertrochanteric left femur</b>		<b>2/13/54</b>	
Conditions contributing to the death but not related to the disease or condition causing death. <b>Cerebral Arterio sclerotic</b>			

19a. DATE OF OPERATION <b>2/4/54</b>	19b. MAJOR FINDINGS OF OPERATION <b>Fracture, intertrochanteric, left femur 4200 F</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <b>Springfield, Greene, MO.</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Feb. 3 1954 m.</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Fell down at Home</b>	

22. I hereby certify that I attended the deceased from **Feb 3** 1954, to **Oct 24**, 1954, that I last saw the deceased alive on **Aug 4**, 1954, and that death occurred at **10:00 a.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>James D. Horton, M.D.</b>	23b. ADDRESS <b>Springfield, Mo.</b>	23c. DATE SIGNED <b>Oct 25, 1954</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>OCT. 26, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>CLEAR CREEK CEMETERY</b>	24d. LOCATION (City, town, or county) (State) <b>GREENE CO. MISSOURI</b>
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DATE REC'D BY LOCAL REG. <b>10-27-54</b>	REGISTRAR'S SIGNATURE <b>Earl Williams</b>	FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Williams &amp; Co. SPFLD. MO.</b>
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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 Rhoads*.....

Licensed Embalmer No. *40*.....

P. O. Address *Spring*.....

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.