

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22647

STATE FILE NUMBER

FILED AUG 1 - 1956

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 217

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Adair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kirksville</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Grim Smith</b> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <b>606 E. Patterson S</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Elizabeth</b> Last <b>Browne</b>			4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>1956</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 12, 1869</b>
9. AGE (In years last birthday) <b>86</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Macon County, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Americus Bertran Collins</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Jane Ellyson</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>None</b>		17. INFORMANT Address <b>Miss Sylva Browne, Kirksville, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO (b) <b>Recurrent cerebral hemorrhage</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b> <b>24 hrs.</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ a. m. _____ p. m. _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>Sept 19 47</b> to <b>July 24, 1956</b> and last saw her alive on <b>July 24, 1956</b> Death occurred at <b>6:35 p.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Norton T. Surline M.D.</b>		22b. ADDRESS <b>Kirksville, Mo.</b>	
22c. DATE SIGNED <b>7.25.56</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7/26/56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>La Plata Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>La Plata, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Paul H. Riley, Kirksville, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>7-25-56</b>	26. REGISTRAR'S SIGNATURE <b>Kate Lambert</b>

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 *Kenneth E Hayes*.....

Licensed Embalmer No. *489*.....

P. O. Address *Kimberly, W.*.....

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.