

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12758

FILED APR 29 1957

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 365-A

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>GREENE</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>SPRINGFIELD</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1307 E PACIFIC</u>		Length of stay in lb <u>6 MO</u>		d. STREET ADDRESS <u>1307 E PACIFIC</u>		(If outside, give location) <u>346</u> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARILYN SUE</u> Middle <u>BUMGARNER</u> Last <u>BUMGARNER</u>				4. DATE OF DEATH Month <u>APR</u> Day <u>13</u> Year <u>1957</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 9 1945</u>			
9. AGE (In years last birthday) <u>7</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>			
13. FATHER'S NAME <u>THOMAS BUMGARNER</u>				14. MOTHER'S MAIDEN NAME <u>SARAH BRYANT</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>SARAH BUMGARNER SPRINGFIELD</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apnea</u> DUE TO (b) <u>metastases to respiratory center</u> DUE TO (c) <u>Brain tumor metastasized</u> 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) <u>193X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year +</u>			
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 <u>---</u> Month <u>---</u> Day <u>---</u> Year <u>---</u> a. m. <u>---</u> p. m. <u>---</u>				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 <u>8-31-56</u> to <u>4-13-57</u> and last saw her/him alive on <u>4-12-57</u> Death occurred at <u>1:00 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>David A. Thomason M.D.</u> (Degree or title)				22b. ADDRESS <u>1630 N Jefferson</u>		22c. DATE SIGNED <u>4-22-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>4-16-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WEAUCH</u>		23d. LOCATION (City, town, or county) (State) <u>WEBSTER CO MO</u>			
24. FUNERAL DIRECTOR <u>BARBER-EDWARDS MARSHFIELD</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>4-24-57</u>		25. REGISTRAR'S SIGNATURE <u>Edith Williamson</u>			

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare
Public
Service

S. 300
y. 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

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.....
R. W. Barber

Licensed Embalmer No. 38

P. O. Address *Mtn Home*

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.