

FILED NOV 25 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1122

S. 300
ev. 1-57

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, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Springfield	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Handley Hosp.		d. STREET ADDRESS (If outside, give location) 849 S. Main	
3. NAME OF DECEASED (Type or print) First ALFRED Middle A. Last DRENNAN		4. DATE OF DEATH Month Nov. Day 19 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Shopman		10b. KIND OF BUSINESS OR INDUSTRY Frisco R.R.	11. BIRTHPLACE (City and state or country) Seymour, Missouri
13a. FATHER'S NAME Hampton Drennan		13b. MOTHER'S MAIDEN NAME Nellie (Unknown)	12. CITIZEN OF WHAT COUNTRY? USA
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. 497-12-7441	17. INFORMANT Address Mary Drennan Springfield, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Disease			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) JAUNE Icteric			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? e YES <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 11/16/57 to 11/19/57 and last saw ^{her} alive on 11/19/57 Death occurred at 10:10 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Lynn D. Brown M.D.		22b. ADDRESS 311 1/2 College	22c. DATE SIGNED 11/20/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-23-57	23c. NAME OF CEMETERY OR CREMATORY Maple Park	23d. LOCATION (City, town, or county) (State) Springfield, Mo.
24. FUNERAL DIRECTOR ADDRESS H.H. Lohmeyer Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 11-22-57	26. REGISTRAR'S SIGNATURE Edith Williamson

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Gene Lehman*

Licensed Embalmer No. *4434*

P. O. Address *April 9*

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.