

Health, Welfare & Public Service
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 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 Doctor, coroner, etc. - must use only standard notation.
 All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

58-008607
 STATE FILE NUMBER

FILED FEB 27 1958

Registration District No. 366 Primary Registration District No. 6240 Registrar's No. 21

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Washington</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hammond</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>1100</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4 mi. W. Palmer</u>		Length of stay in lb <u>6.5 years</u>	d. STREET ADDRESS (If outside, give location) <u>47th W. Palmer</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lyntha Eva Breakfield</u>			4. DATE OF DEATH Month Day Year <u>Feb. 20 1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 23 1870</u>
9. AGE (In years last birthday) <u>87</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (City and state or country) <u>Crawford Co. Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Bert William</u>	
13b. MOTHER'S MAIDEN NAME <u>Melendia Stetter</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or "unknown") (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>334X</u>	
17. INFORMANT <u>James Breakfield</u>		Address <u>Rt. 2 Potosi Mo.</u>	
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>Apoplexy</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>arterio sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
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? YES <input type="checkbox"/> NO <input checked="" 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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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>July 1 - 1957</u> to <u>Feb 20 - 58</u> and last saw ^{her} alive on <u>Feb - 18 - 1958</u> Death occurred at <u>7:15 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph L. Hurman - M.D.</u>		22b. ADDRESS <u>121 E. High Potosi, Mo.</u>	
22c. DATE SIGNED <u>2-23-58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-23-58</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Shoal Creek Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Washington Co. Mo.</u>	
24. FUNERAL DIRECTOR <u>Mrs. Lulu Sparks Potosi Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2/25/58</u>	
26. REGISTRAR'S SIGNATURE <u>H. E. ...</u>			

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 *Murphy L Sparker*

Licensed Embalmer No. *4236*

P. O. Address *Flat River m*

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.