

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-017885  
STATE FILE NUMBER

FILED MAY 26 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 530

300  
1-57

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, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Springfield</b> 0396/10 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>City Hospital</b>		Length of stay in lb <b>83 Yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>2220 N. Summit</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>MALLIE</b> Middle <b>ANN</b> Last <b>RYAN</b>			4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>1958</b>	
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</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>30 Jan. 1870</b>	9. AGE (In years and birth day) <b>88</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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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>Home</b>	11. BIRTHPLACE (City and state or country) <b>Tennessee</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>James Fishburne</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Deceased</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input type="checkbox"/> or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Hospital Records</b> Address
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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>Cardio-renal Disease</b> DUE TO (b) <b>Fractured Hips</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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.)
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20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ 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 <b>Springfield</b>	COUNTY <b>Greene</b>	STATE <b>Missouri</b>
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21. I attended the deceased from <b>April 14 - 1958</b> to <b>May 5, 1958</b> and last saw her alive on <b>5/21/58</b> Death occurred at <b>9:35 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>Leman H. Brown M.D.</b> (Degree or title)	22b. ADDRESS <b>31 1/2 College</b>	22c. DATE SIGNED <b>5/21/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5-23-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn</b>	23d. LOCATION (City, town, or county) <b>Springfield, Missouri</b>
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24. FUNERAL DIRECTOR <b>Junkin &amp; Co. Spfld. Mo.</b> ADDRESS	25. DATE RECD. BY LOCAL REG. <b>5-22-58</b>	26. REGISTRAR'S SIGNATURE <b>Effie G. Melton</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

MEDICAL CERTIFICATION

**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 *Glen D Williams* .....

Licensed Embalmer No. *4651* .....  
P. O. Address *Springfield* .....

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.