

Health, Welfare, Public Service

Dr. Turner

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-021525
STATE FILE NUMBER

FILED JUL 7 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 669

300
-57

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY OREGON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN THAYER 0750 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.		Length of stay in 1b 1 MONTH	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last BESSIE GERTRUDE BROWN			4. DATE OF DEATH Month Day Year JUNE 27 1958
5. SEX FEMALE	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 FEB. 14 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BEAUTICIAN		10b. KIND OF BUSINESS OR INDUSTRY BEAUTY SHOP OWNER	11. BIRTHPLACE (City and state or country) GAINESVILLE, ARK.
13a. FATHER'S NAME MARTIN L. WOOD		13b. MOTHER'S MAIDEN NAME LUCINDA TEAGUE	14. NAME OF HUSBAND OR WIFE RAN BROWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, NO unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 494-34-6316	17. INFORMANT Address RAN BROWN THAYER, 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) PROBABLE COMPLETE ATRIAL DYSRHYTHMIA BLOCIC Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) INFARCTION OF MYOCARDIUM DUE TO (c) ARTEMOSCLEROTIC CORONARY THROMBOSIS			INTERVAL BETWEEN ONSET AND DEATH FEW MIN - 6 WKS.
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 5-29-58 to 6-27-58 and last saw him alive on 6/22/58 . Death occurred at 4 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dr. Turner		22b. ADDRESS M.D. 609 Cherry-Springfield, Mo.	22c. DATE SIGNED 6-28-58
23a. BURIAL, CREMATION, REMOVAL REMOVAL	23b. DATE 6/28/58	23c. NAME OF CEMETERY OR CREMATORY RIVERSIDE	23d. LOCATION (City, town, or county) (State) MAMMOTH SPRINGS, ARK.
24. FUNERAL DIRECTOR CARTER FUNERAL HOME THAYER, MO.		25. DATE RECD. BY LOCAL REG. 6-30-58	26. REGISTRAR'S SIGNATURE E. J. Meltzer

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 *W. J. McClean*

Licensed Embalmer No. *7737*
P. O. Address *Springfield, Mo.*

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.