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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-039500

STATE FILE NUMBER

FILED DEC 15 1958

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 1181

5. 300
1-57

All diseases in Part I must be causally related. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 St. Johns Hospital		d. STREET ADDRESS (If outside, give location) 759 S. Missouri	
3. NAME OF DECEASED (Type or print) First Middle Last Ruth Bradley		4. DATE OF DEATH Month Day Year Dec. 6 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Missouri
13a. FATHER'S NAME John Callaway		13b. MOTHER'S MAIDEN NAME Nancy Morris	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 486-40-9896	17. INFORMANT Address HOSPITAL RECORDS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lympho Sarcoma Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH NK
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 o.m. p.m.			
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 6-4-58 , to 12-6-58 and last saw her ^{her} _{him} alive on 12-5-58 Death occurred at 6:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Mr. Vets (Degree or title)		22b. ADDRESS 1715 BOONVILLE SPRINGFIELD MISSOURI	
		22c. DATE SIGNED 12-8-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-8-58	
23c. NAME OF CEMETERY OR CREMATORY SPARTA CEMETERY		23d. LOCATION (City, town, or county) (State) SPARTA, MO.	
24. FUNERAL DIRECTOR J.W. Klingner + Co. ADDRESS Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 12-9-58	
		26. REGISTRAR'S SIGNATURE Effie G. Melton	

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 *Max Rhoads*

Licensed Embalmer No. *4071*

P. O. Address *Spring*

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.