

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000923  
STATE FILE NUMBER

FILED JAN 12 1959 Registration District No. 128 Primary Registration District No. 200 Registrar's No. 8

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Webster</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Rogersville</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Hosp.</u>		Length of stay in 1b <u>3 wks.</u>	d. STREET ADDRESS (If outside, give location) <u>1126</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET ENID BROOKS</u>			4. DATE OF DEATH Month Day Year <u>JAN. 1, 1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 9, 1922</u>	9. AGE (In years last birthday) <u>36</u>	IF UNDER 1 YEAR Months Days <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>Calcutta, India</u>	12. CITIZEN OF WHAT COUNTRY? <u>ENGLAND</u>	

13a. FATHER'S NAME <u>Samuel James Strong (Dec)</u> <del>SAMUEL STRONG</del>	13b. MOTHER'S MAIDEN NAME <u>Sarah Josephine White</u> <del>UNKNOWN</del>	14. NAME OF HUSBAND OR WIFE <u>George Daniel Brooks</u> <del>George D.</del>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>George D. Brooks, Rogersville, 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>Circulatory Collapse</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Essential Pulmonary Hypertension over 10 yrs</u>	
	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? YES <input checked="" 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.) <u>ITEM 13a, 13b, 14 CORRECTED</u>
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	BY AFFIDAVIT OF <u>Informant</u> <u>2-13-59 DET</u>

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 <u>Springfield, mo</u>	COUNTY <u>Greene</u>	STATE <u>MO</u>
21. I attended the deceased from <u>5/15/58</u> to <u>1/1/59</u> and last saw him alive on <u>12/31/58</u> Death occurred at <u>2:35 a</u> m on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) <u>David W. Hall, M.D.</u>		22b. ADDRESS <u>Springfield, mo</u>		22c. DATE SIGNED <u>1/5/59</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>JAN. 4, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Palmetto Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Rogersville Rural, mo.</u>
24. FUNERAL DIRECTOR <u>W. C. Jewell, Rogersville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-5-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>

(Licensed Embalmer's Statement on Reverse Side)

David W. Hall, M.D.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION  
 All diseases in Part I must be causally related.

MS FEB 13 1953

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 *Ray L. Farrel* .....

Licensed Embalmer No. *4847* .....

P. O. Address *Hampfield, 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.