

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012915
STATE FILE NUMBER

FILED MAY 4 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 394c

300
1-57

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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield <u>0396</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR RESIDENCE INSTITUTION 650 S. Nettleton		Length of stay in lb Years	d. STREET ADDRESS (If outside, give location) 650 S. Nettleton		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First NATHAN Middle BRUCE Last BILLINGSLY			4. DATE OF DEATH Month APRIL Day 14 Year 1959		
5. SEX Male	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 Unknown		9. AGE (In years last birthday) Unknown IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (City and state or country) Unknown <u>7</u>	
12. CITIZEN OF WHAT COUNTRY? USA					
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Mrs. Warnick <u>650 S. Nettleton Springfield, 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) Cardio Renal disease				INTERVAL BETWEEN ONSET AND DEATH 2 Weeks	
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)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>	
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>4/2X</u>		
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>4-1-59</u> to <u>4-14-59</u> and last saw ^{toX} him alive on <u>April 14, 1959</u> Death occurred at <u>1:15</u> PM on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Wm. D. Brown</u> WYMAN D. BROWN M. D.			22b. ADDRESS Springfield, Missouri		22c. DATE SIGNED 4-23-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4-29-59	23c. NAME OF CEMETERY OR CREMATORY Kirksville, Mo		23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR AYRE-GOODWIN: SPRINGFIELD, MO			25. DATE RECD. BY LOCAL REG. 4-29-59		26. REGISTRAR'S SIGNATURE Effie S. Mellen

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Robert M. Brown*

Licensed Embalmer No. *4732*

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.