

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 21 1959

59-031967

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 976

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> COUNTY <u>GREENE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		Length of stay in 1b	c. CITY OR TOWN <u>SPRINGFIELD</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BURGE HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>517 E. ELM</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>BRITE</u> Last <u>BRITE</u>	4. DATE OF DEATH Month <u>SEPT.</u> Day <u>16</u> Year <u>1959</u>
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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>29 MAY 1890</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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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>HOME</u>	11. BIRTHPLACE (City and state or country) <u>ARKANSAS</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>JOHN ACKERS</u>	13b. MOTHER'S MAIDEN NAME <u>MARTHA INMON</u>	14. NAME OF HUSBAND OR WIFE <u>LON BRITE</u>
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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>NO</u>	17. INFORMANT <u>UNKNOWN HOSPITAL RECORDS</u>	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) <u>Acute Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Post-operative Aortic Aneurysm</u>	<u>1 yr.</u>
	DUE TO (c) <u>General Arteriosclerosis</u>	<u>many yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bilateral nephrolithiasis</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year
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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	COUNTY	STATE
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21. I attended the deceased from 9-1-59 to 9-16-59 and last saw her alive on 9-16-59
Death occurred at 1:30 P. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J.R.D. Duncan, M.D.</u>	(Degree or title)	22b. ADDRESS <u>Springfield, MO</u>	22c. DATE SIGNED <u>9/17/59.</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9-18-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MAPLE PARK</u>	23d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD MO.</u>
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24. FUNERAL DIRECTOR <u>KLINGNER MORTUARY</u>	ADDRESS <u>SPRFD. MO.</u>	25. DATE RECD. BY LOCAL REG. <u>9-18-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Meeton</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 10 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Catherine King

Licensed Embalmer No. 3719

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.