

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 9 6 4

FILED VS DEC 28 1959

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1368

ENDED

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>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>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Handley</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>712 State Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ARIZONA</u> Middle _____ Last <u>WALL</u>				4. DATE OF DEATH Month <u>December</u> Day <u>16</u> Year <u>1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3-24-1876</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
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		11. BIRTHPLACE (City and state or country) <u>Marble, Arkansas</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Benjamin Burkett</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth McDonald</u>			14. NAME OF HUSBAND OR WIFE <u>Charles D. Wall</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hugh Wall--Berryville, Arkansas</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>Hypostatic Pneumonia</u> DUE TO (b) <u>Fractured Hip</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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>Fallout of bed at Nursing Home</u>						
20c. TIME OF INJURY Hour _____ a.m. _____ <u>11/4/59</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <u>Forsters Nursing Home</u>							
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Forsters Nursing Home</u>	20f. CITY, TOWN, OR LOCATION <u>Springfield</u>		COUNTY <u>Greene</u>		STATE <u>Mo.</u>			
21. I attended the deceased from <u>11/4/59</u> to <u>12/16/59</u> and last saw her <u>alive</u> on <u>12/15/59</u> Death occurred at <u>6:30</u> A.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Leman D. Brown M.D.</u>				22b. ADDRESS <u>311 1/2 College</u>			22c. DATE SIGNED <u>12/22/59</u>	
23a. BURIAL, CREMATION, RECOVERY (Specify) <u>Burial</u>		23b. DATE <u>12-9-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Berryville Mem. Park</u>		23d. LOCATION (City, town, or county) <u>Berryville, Arkansas</u>			
24. FUNERAL DIRECTOR <u>Nelson Funeral Home--Berryville, Ark.</u>				25. DATE RECD. BY LOCAL REG. <u>12-24-59</u>		26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

For Dr. Brown

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 Harold Butrell

Licensed Embalmer No. 5079

P. O. Address Spokane, Wash.

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.