

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014807

STATE FILE NUMBER

FILED VS. MAY 16 1960 / 28

Registration District No. 2000 Primary Registration District No. 543 Registrar's No.

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Greene</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>			Length of stay in 1b		c. CITY OR TOWN <b>Springfield</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Johns Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1510 W. Florida</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>L.</b> Last <b>BROWN</b>				4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>24 June 1893</b>	9. AGE (last birthday) <b>66</b>	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) <b>Railroad Conductor</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (City and state or country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Joseph Brown</b>			13b. MOTHER'S MAIDEN NAME <b>Maggie Davis</b>			14. NAME OF HUSBAND OR WIFE <b>Eva Brown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Eva Brown (Wife) Springfield, Mo.</b> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tracheobronchitis, acute</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
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) <b>Pul. emphysema, cor pulmonale bronchiectasis</b>					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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year							
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
21. I attended the deceased <b>on 5/7/60</b> and last saw <sup>her</sup> him alive on <b>5/6/60</b> Death occurred at <b>3:15</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>G. B. Lemmon MD</b> (Degree or title)				22b. ADDRESS <b>615 Cherry Springfield, Mo.</b>			22c. DATE SIGNED <b>5-9-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/9/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>White Chapel Cemetery</b>		23d. LOCATION (City, town, or county) <b>Springfield, Mo.</b>		(State)
24. FUNERAL DIRECTOR <b>Klingner Mortuary</b> ADDRESS <b>Springfield, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>5-11-60</b>		26. REGISTRAR'S SIGNATURE <b>Effie B. Melton</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

jhc

(Licensed Embalmer's Statement on Reverse Side)

APR 19 1961

MAY 18 1960

**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 Max Rhodes

Licensed Embalmer No. 40

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.