

MORTUARY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014810
STATE FILE NUMBER

FILED VS MAY 2 1960

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 483

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo' b. COUNTY Greene					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Length of stay in lb 60 yrs		c. CITY OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION D O A Handley			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 716 N Weaver St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Rosa Middle Bryant Last Bryant				4. DATE OF DEATH Month April Day 24 Year 1960					
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Sept '16 1885	9. AGE (last birthday) 75	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Cave Springs Mo'		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Unknown			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Address Minnie Trout 2115 N Washington				
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 - Pulmonary Disease							INTERVAL BETWEEN ONSET AND DEATH		
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)						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 type="checkbox"/> NO <input checked="" 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.)							
20c. TIME OF INJURY Hour _____ a.m. _____ 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 from <u>1955</u> to <u>1960</u> and last saw her <u>alive</u> on <u>April 15, 1960</u> Death occurred at <u>1:15 pm</u> the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Lyman D. Brown M.D.				22b. ADDRESS 311 1/2 College				22c. DATE SIGNED 4/25/60	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)			
Burial		April 28 1960	Hazelwood			Springfield		Mo'	
24. FUNERAL DIRECTOR ADDRESS H V Smith 602 N Jefferson St.				25. DATE RECD. BY LOCAL REG. 4-28-60		26. REGISTRAR'S SIGNATURE Effie S. Melton			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Herbert V Smith

Licensed Embalmer No. 4286
P. O. Address Springfield
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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.