

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024961
STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 103

AMENDED

FILED JUL 24 1961

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Howell</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Ozark</u> | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains, Mo.</u> | | c. CITY OR TOWN <u>Dora</u> | |
| Length of stay in 1b <u>days</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>Memorial Hospital</u> | | d. STREET ADDRESS (if outside, give location) | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|---|---------------------------------|---|---|---|--|--|
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Britt</u> | | | 4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1961</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>wht.</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>1-5-1888</u> | 9. AGE (last birthday) <u>73 yrs.</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u> | | 11. BIRTHPLACE (City and state or country) <u>Dallas City, Ill</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> |
| 13a. FATHER'S NAME <u>Robert Britt</u> | | 13b. MOTHER'S MAIDEN NAME <u>Lucy Woods</u> | | 14. NAME OF HUSBAND OR WIFE <u>Lucretia Sprouts</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>yes</u> | | 17. INFORMANT Address <u>Mrs. W. H. Britt, Dora, Mo.</u> | | |

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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: | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> | | <u>48 hrs</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Hypostatic Pneumonia</u> | | <u>4 days</u> |
| | DUE TO (c) <u>Emphysema</u> | | <u>12 wks</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease</u> | | | 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 |

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|---|---|--|--------------|
| 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 <u> </u> a.m. <u> </u> p.m. <u> </u> | Month, Day, Year <u> </u> <u> </u> <u> </u> | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 5-20-61 to 7-3-61 and last saw him alive on 7-3-61
Death occurred at 5:45 P M on the date stated above, and to the best of my knowledge, from the causes stated.

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|--|--|--|--|---|--|
| 22a. SIGNATURE (Degree or title) <u>Murray T. Pritchard, M.D.</u> | | 22b. ADDRESS <u>913 W Main, West Plains, Mo</u> | | 22c. DATE SIGNED <u>7-14-61</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>7-8-1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Sweeton Cemetery</u> | |
| 24. FUNERAL DIRECTOR <u>Robertsons, West Plains, Mo.</u> | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. <u>7-19-61</u> | |
| | | | | 26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u> | |

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

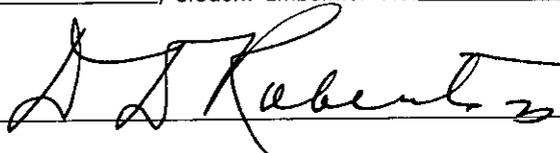
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 3432

P. O. Address West Plains, 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.