

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-019692

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 766

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 27 1963

VS 300
Rev. 4/59

1 1397
2 0840

4 1
5 1

7 0
8 1

9 1930

12 4-0
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
(INSTEAD OF)

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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>Polk</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>Humansville</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Johns Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RFD#2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LELA</u> Middle <u>MARIE</u> Last <u>BROWN</u>		4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1963</u>	
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>3-6-1911</u>
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>	9. AGE (last birthday) <u>52</u> IF UNDER 1 YEAR: Months <u>52</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> 11. BIRTHPLACE (City and state or country) <u>HICKORY COUNTY, Mo</u> 12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>JOHN H. BULLINGTON</u>		13b. MOTHER'S MAIDEN NAME <u>JANE SANDERS</u>	14. NAME OF HUSBAND OR WIFE <u>Edgar Brown</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>[redacted]</u>	17. INFORMANT Address <u>Edgar Brown (Husband) Rt. 2 Humansville, Mo.</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>Brain malignant</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (e), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
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 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.)	
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>5-11-63</u> to <u>5/18/63</u> and last saw her alive on <u>5/18/63</u> Death occurred at <u>1:55</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>John D. K. [unclear] M.D.</u>		22b. ADDRESS <u>Springfield, Missouri</u>	22c. DATE SIGNED <u>5-21-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>5-20-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HUMANSVILLE CEME.</u>	23d. LOCATION (City, town, or county) (State) <u>HUMANSVILLE, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Beckwith Funeral Home Humansville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>5-22-63</u>	26. REGISTRAR'S SIGNATURE <u>Effie B. Melton</u>

MAY 28 1963

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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 Glen D. Williams

Licensed Embalmer No. 4651

P. O. Address Springfield 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.