

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**=63-019710**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **128**

Primary Registration District No. \_\_\_\_\_

Registrar's No. **720**

**FILED MAY 20 1963**

VS 300 Rev. 4/59	DATE AMENDED
1 <b>0390</b>	
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<b>9334X</b>	
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12 <b>90-0</b>	
13	

Lyman W. Brown, M.D.  
 USE BLACK INK  
 OR  
 TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 <b>20 Years</b>	c. CITY OR TOWN <b>Springfield</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Sunshine Acres</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Sunshine Acres</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>FELIX</b> Last <b>EAST</b>			4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/15/1877</b>
9. AGE (last birthday) <b>85</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>Ret. Blacksmith</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Blacksmith</b>	11. BIRTHPLACE (City and state or country) <b>Lawrence County, Ark.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>David R. East</b>	
13b. MOTHER'S MAIDEN NAME <b>Armanda</b>		14. NAME OF HUSBAND OR WIFE <b>Dollie East</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv.) <b>No</b> <b>None</b>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>Rt. <sup>Address</sup></b>		<b>Mrs. Louise Towe, Springfield, Missouri</b>	
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>Cerebrovascular Disease</b>			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 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 <b>Jan 1963</b> to <b>May 12, 1963</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>May 8, 1963</b> Death occurred at <b>8:30 P.M.</b> m on the date stated above, and to the best of my knowledge from the causes stated.			
22a. SIGNATURE (Denote or title) <b>Lyman W. Brown M.D.</b>		22b. ADDRESS <b>311 1/2 College</b>	22c. DATE SIGNED <b>5/15/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5-13-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Manila Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Manila, Arkansas</b>
24. FUNERAL DIRECTOR <b>Ralph Thieme, Springfield, Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>5-15-63</b>	26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b> SW	

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Permit 5-13-63

**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 *Michael L. Strauss*

Licensed Embalmer No. 5164

P. O. Address *Appt, 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.