RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-029276
STATE FILE NUMBER

FILED VS AUG 8 1960 324 Registration District No. Primary Registration District No. 3072 Registrar's No. 146

DED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY: Saline		a. STATE: Missouri b. COUNTY: Saline	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Marshall	Length of stay in 1b: 1 Month	c. CITY OR TOWN: Malta Bend	Inside Limits: Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Fitzgibbon Hosp.	Inside Limits: Yes ☒ No ☐	d. STREET ADDRESS (If outside, give location): 3 M W Malta Bend	Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month Day Year
FLOY		BROWNFIELD	August 3, 1960

5. SEX	6. COLOR OR RACE	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HR Hours	Min.
Female	White		9-19-1884	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
Housewife	Home	Henry Co. Mo.	USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
W.S. Goodin	Betty Duncan Goodin	W.I. Brownfield

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	no	no	W.I. Brownfield RR 2 Malta Bend

MEDICAL CERTIFICATION

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)	Respiratory Insufficiency –	6 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Acute Cardiac failure	6 hrs
DUE TO (c)	Case of Lung.	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Canc. Breast, ovarian Regression Lung Liver Bones

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒	20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐	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 ☐ NOT WHILE AT WORK ☐	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 Dec 1958 to Aug 3, 1960 and last saw him alive on Aug 3, 1960

Death occurred at 9:05 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
B Kuykendall MD	Marshall, Missouri	Aug 4-60

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	8-5-1960	Windsor Calhoun Cemetery	Windsor Calhoun Missouri

24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Sweeney-Reser Funeral Home Marshall	8-4-60	Cecil G. Read

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Jack M. Rose

Licensed Embalmer No. 4643

P. O. Address Marshall,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.