

No. 300
10.48

FILED FEB 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 985

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 104

39
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE 8 Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	
d. FULL NAME OF HOSPITAL OR INSTITUTION 604 W. Madison		d. STREET ADDRESS (If rural, give location) 604 W. Madison	

3. NAME OF DECEASED (Type or Print) a. (First) Ida b. (Middle) J c. (Last) Tribble			4. DATE OF DEATH Feb. 4 1949 (Month) (Day) (Year)		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 13 1867	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Boone Co. Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Sexton	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Andrew J.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No.	17. INFORMANT'S SIGNATURE OR NAME Mrs. Rella Adair Brimmonella	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Occlusion		INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral - Renal - Vascular Disease			1 yr.
	DUE TO (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 442	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 0
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22. I hereby certify that I attended the deceased from **1-20**, 19**49**, to **2-4**, 19**49**, that I last saw the deceased alive on **2-4**, 19**49**, and that death occurred at **6:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Max J. ...	(Design of title) M.D.	23b. ADDRESS Springfield Mo	23c. DATE SIGNED 2-4-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE Feb 7, 1949	24c. NAME OF CEMETERY OR CREMATORY Centralia	24d. LOCATION (City, town, or county) (State) Centralia Mo.
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DATE REC'D BY LOCAL REG. 2-4-49	REGISTRAR'S SIGNATURE W. E. Hendry M.D.	25. FUNERAL DIRECTOR'S SIGNATURE J. W. Klingner & Co.	ADDRESS Springfield
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FEB 14 1949

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
Student Embalmer

Signed Ogle Stone Jr.

Licensed Embalmer No. 4176

P. O. Address Springfield

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 this body is not embalmed, fact should be so stated above.