

FILED JUN 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15499

BIRTH NO. _____		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 2000		Registrar's No. 510	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY GREENE		a. STATE MISSOURI		b. COUNTY GREENE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (In this place) 30 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		39	
d. FULL NAME OF HOSPITAL OR INSTITUTION BURGE				d. STREET ADDRESS (If incl. give location) 317 1/2 BOOKVILLE			
3. NAME OF DECEASED			4. DATE OF DEATH				
a. (First) ELSIE	b. (Middle) —	c. (Last) BRESSIE	Month JUNE	Day 7	Year 1949		
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH Feb 1, 1891	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months 3	IF UNDER 24 HRS. Days 6	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rooming House		10b. KIND OF BUSINESS OR INDUSTRY Boarding		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME W. C. Vandiver		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE George Bressie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT'S SIGNATURE OR NAME George Bressie			
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bile peritonitis		DUE TO (b) Rupture of old gall bladder stones		4 days	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) Cardio-renal disease with hypertension		5 to 6 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-3-1949, to 6-7-1949, that I last saw the deceased alive on 6-7-1949, and that death occurred at 1:00 A.M., from the causes and on the date stated above.							
23a. SIGNATURE M. G. Haulby M.D.		(Degree or title)		23b. ADDRESS Medical Bldg Springfield Mo		23c. DATE SIGNED 6-7-49	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 6/11/49	24c. NAME OF CEMETERY OR CREMATORY Springfield		24d. LOCATION (City, town, or county) (State) Springfield, Mo.		
DATE REC'D BY LOCAL REG. 7/8/49		REGISTRAR'S SIGNATURE W. C. Haulby M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Mrs. Lorraine Turner of Home			

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Signed.....

Jewell E. Hinds

Signed.....
Student Embalmer

Licensed Embalmer No. *2831*

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.