

FILED AUG 31 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26703

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5465 Registrar's No. 751

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>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Campbell township</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Campbell Township</u>	
c. LENGTH OF STAY (in this place) <u>20 years</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2741 West Walnut</u>		d. STREET ADDRESS (If rural, give location) <u>2741 W Walnut, Springfield, Mo</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Bertha</u>	b. (Middle) <u>Edwards</u>	c. (Last) <u>Livingston</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>August 20 1949</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 9, 1897</u>	9. AGE (In years last birthday) <u>52</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housework</u>		11. BIRTHPLACE (State or foreign country) <u>Christian Co., Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>John Edwards</u>	13b. MOTHER'S MAIDEN NAME <u>Onar Faught</u>	14. NAME OF HUSBAND OR WIFE <u>Clarence Livingston</u>
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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>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Clarence Livingston, Springfield, Mo.</u>	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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u> <u>4 1/2 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Rheumatic Heart Disease with mitral stenosis, and</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>irregular fibrillation and congestive failure</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: <u>Eng. Arteriosclerosis</u>			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Minute) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 6/17/48, 19____, to 8/20/49, 19____, that I last saw the deceased alive on 8/20/49, 19____, and that death occurred at 8:40 P m., from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) <u>Blenn O. Turner, M.D.</u>	22b. ADDRESS <u>Springfield, Mo.</u>	22c. DATE SIGNED <u>8/24/49</u>
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24a. BURIAL, CREMATION, REMOVAL, BURIAL (Specify) <u>Burial</u>	24b. DATE <u>Aug. 22, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>McConnell Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>near Springfield, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>8-24-49</u>	REGISTRAR'S SIGNATURE <u>W.S. Dudley M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Schmeizer F.H. Springfield Mo</u>	ADDRESS <u>B.F.W.</u>
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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.

Student
Student Embalmer

Signed Lee Mason.....

Licensed Embalmer No. 4568.....

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