

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

387777

State File No. ....

FILED NOV 23 1953

BIRTH NO. 51100 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 1030

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Greene</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>2 mon</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u> 0396		d. STREET ADDRESS (If rural give location) <u>926 E Pythian</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>City Hospital</u>				d. STREET ADDRESS (If rural give location) <u>926 E Pythian</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>PATRICIA</u>		b. (Middle) <u>ANN</u>		c. (Last) <u>JOHNSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11 13 53</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Infant</u>		8. DATE OF BIRTH <u>9-8-53</u>			
9. AGE (In years last birthday) <u>2</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Springfield Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Unknown</u>				13b. MOTHER'S MAIDEN NAME <u>Genevieve Johnson</u>		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Genevieve Johnson</u> ADDRESS <u>923 Pythian</u>					
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchopneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>atelectasis</u> DUE TO (c) <u>Malnutrition &amp; Dehydration</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
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) <u>7720</u>					
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 <u>Nov 7</u> , 19 <u>53</u> , to <u>Nov 13</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Nov 13</u> , 19 <u>53</u> , and that death occurred at <u>9 A.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Lynn H. Brown M.D.</u> (Degree or title)				23b. ADDRESS <u>307 1/2 College</u>		23c. DATE SIGNED <u>Nov 13 1953</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11-14-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Cave Springs Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Cave Springs Mo</u>			
DATE REC'D BY LOCAL REG. <u>11-16-53</u>		REGISTRAR'S SIGNATURE <u>Earl Williamson</u>		25. GENERAL DIRECTOR'S SIGNATURE <u>H.V. Smith</u> ADDRESS <u>602 N. Jefferson</u>					

(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.

Student .....  
Student Embalmer

Signed *Not Embalmed* .....

Licensed Embalmer No. ....

P. O. Address .....

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

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