

FILED OCT 11 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30298

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 926

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY OR TOWN Springfield	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 6 weeks		e. STREET ADDRESS (If rural, give location) 717 North Prospect 0390	
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) SUDIE b. (Middle) ENGELBRECHT c. (Last) HENDRICKS			4. DATE OF DEATH (Month) (Day) (Year) October 6 1954		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 21, 1881	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and State or Foreign Country) Brazito, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John F Engelbrecht	13b. MOTHER'S MAIDEN NAME Louise Kingery	14. NAME OF HUSBAND OR WIFE _____
----------------------------------------------	-------------------------------------------------	-----------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Miss Florence Hendricks, Springfield, Mo.	ADDRESS _____
-----------------------------------------------------------------------------	-------------------------------------	------------------------------------------------------------------------------------	---------------

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 8 mos 3 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of parotid gland = metastases.		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Broncho pneumonia. DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____			

19a. DATE OF OPERATION 3/29/54	19b. MAJOR FINDINGS OF OPERATION at Ellis Fischel Hosp. Same 1421	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 **4/30, 1954**, to **10/6, 1954**, that I last saw the deceased alive on **10/6, 1954**, and that death occurred at **3:15p. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Chas. E. Lockhart MD	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 10/7/54
--------------------------------------------------------------	--------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct 9, 1954	24c. NAME OF CEMETERY OR CREMATORY Gott Cemetery	24d. LOCATION (City, town, or county) (State) Near Ullman, Missouri
---------------------------------------------------------	------------------------------	---------------------------------------------------------	----------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. 10-9-54	REGISTRAR'S SIGNATURE Evelyn Williamson	25. FUNERAL DIRECTOR'S SIGNATURE Alma Schmeyer	ADDRESS Springfield, Mo.
-----------------------------------------	------------------------------------------------	-------------------------------------------------------	---------------------------------

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.....
Signature of Student Embalmer

Signed *Robert E. Muhleman*

Licensed Embalmer No. *491*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.