

FILED NOV 7 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32922

State File No.

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5453 Registrar's No. 962

| | | | |
|---|--|---|---|
| 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 BROOKLINE | | c. CITY OR TOWN BROOKLINE | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION BROOKLINE | | e. STREET ADDRESS (If rural, give location) BROOKLINE, MO. | |

| | | | | | | |
|---|-------------------------------|---|--|---|---|-----------------------------|
| 3. NAME OF DECEASED (Type or Print) a. (First) FANNIE b. (Middle) P. c. (Last) TUTER | | | 4. DATE OF DEATH (Month) (Day) (Year) Oct 28, 1955 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED | 8. DATE OF BIRTH May 4, 1880 | 9. AGE (In years last birthday) 75 | 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) HOUSE WIFE | | 10b. KIND OF BUSINESS OR INDUSTRY IN HOME | 11. BIRTHPLACE (City and State or Foreign Country) MISSOURI | | 12. CITIZEN OF WHAT COUNTRY? USA | |

| | | | | | |
|--|--|---|--|--|--|
| 13a. FATHER'S NAME SAM PHILLIPS | | 13b. MOTHER'S MAIDEN NAME ELLA HAYES | | 14. NAME OF HUSBAND OR WIFE WIDOWED | |
| 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 FLOSSIE TUTER, 729 N NETTLETON | |

| | | | | | |
|---|--|---|--|--|---|
| 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic heart disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u> |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis</u> | | | |
| | | DUE TO (c) _____ | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | <u>4200</u> |

| | | | | | | |
|--|--|--|--|---|---|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | 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) (Min.) | | 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 1-, 19 50 to 10-28-, 1955, that I last saw the deceased alive on 10-12-, 19 55 and that death occurred at 8:00p m., from the causes and on the date stated above.

| | | | | | |
|--|--|---|--|--|--|
| 23a. SIGNATURE (Degree or title) <u>A. M. Klinger M.D.</u> | | 23b. ADDRESS <u>1630 N Jefferson</u> | | 23c. DATE SIGNED <u>10-29-55</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24b. DATE OCT 30, 1955 | | 24c. NAME OF CEMETERY OR CREMATORY BROOKLINE CEMETERY | |
| DATE REC'D BY LOCAL REG. <u>10-31-55</u> | | REGISTRAR'S SIGNATURE <u>Edith Williamson</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. ...</u> ADDRESS SPRINGFIELD, MISSOURI | |

(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.....
Signature of Student Embalmer

Signed *Wm. S. Williams*

Licensed Embalmer No. *461*

P. O. Address *Spring*

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.