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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 20691

FILED JUL 1 1957 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 563-A

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Springfield — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Handley City Hosp. — Length of stay in Hospital: 8 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Greene
c. CITY OR TOWN: Springfield — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 2104 W. Lee — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Jodie Middle: Last: Brownfield

4. DATE OF DEATH Month Day Year: June 19, 1957

5. SEX: Male **6. COLOR OR RACE:** White **7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 5, 1948

9. AGE (In years last birthday): 9 — 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): Student
10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Brownfield
14. MOTHER'S MAIDEN NAME: Goldie Collicoat

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: City Hospital, Springfield, Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Liver Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 month
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Infectious Hepatitis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 092X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 6-11-57, to 6-19-57 and last saw him alive on 6-19-57
Death occurred at 9:00 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Lewis A. Coffin Jr MD.
22b. ADDRESS: City Hospital, Springfield
22c. DATE SIGNED: 6-19-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 6-19-57
23c. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery
23d. LOCATION (City, town, or county) (State): Buffalo, Missouri

24. FUNERAL DIRECTOR: Jones **ADDRESS:** Buffalo, Missouri
25. DATE RECD. BY LOCAL REG.: 6-26-57
26. REGISTRAR'S SIGNATURE: Edith Williamson

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Leonard B. Jones

Licensed Embalmer No. 2

P. O. Address Buff

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
-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.