

Dr. Brown

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013840

STATE FILE NUMBER

FILED APR 28 1958

Health,
& Welfare
Public
Service

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 420

300

1-57

SPRINGFIELD, MISSOURI

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Medical Certification

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed-36 East Pacific
All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY GREENE 0396	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR SPRINGFIELD TOWN		c. CITY OR TOWN SPRINGFIELD	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS (If outside, give location) 2106 N. Benton	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FREDA HIGHT			4. DATE OF DEATH Month Day Year April 19, 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 July 1923
9. AGE (In years last birthday) 34	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME LeRoy Arnold		13b. MOTHER'S MAIDEN NAME Anna Tate	14. NAME OF HUSBAND OR WIFE O.H. Hight
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Hospital Records
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			416X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 4/4/58 to 4/19/58 and last saw her alive on 4/18/58 Death occurred at 4:05 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Lyman D. Brown M.D.		22b. ADDRESS 311 1/2 College Springfield, Missouri	22c. DATE SIGNED 4/19/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-22-58	23c. NAME OF CEMETERY OR CREMATORY Lebanon, Cemetery	23d. LOCATION (City, town, or county) (State) Lebanon, Mo.
24. FUNERAL DIRECTOR J. Klingner & Co.		25. DATE RECD. BY LOCAL REG. 4-22-58	26. REGISTRAR'S SIGNATURE Effie G. Melton
ADDRESS Spfld. Mo.			

(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 embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Max Rhodes*

Licensed Embalmer No. *4071*
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.