

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028781
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 833

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, give TOWNSHIP only) OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SPRINGFIELD <u>0396</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BURGE HOSPITAL		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 2150 N. WELLER Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last DAISY GERTRUDE BROWN			4. DATE OF DEATH Month Day Year AUGUST 23, 1958		
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 APRIL 1897	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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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
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13a. FATHER'S NAME ANES HUDDLESTON	13b. MOTHER'S MAIDEN NAME SARAH GAULY	14. NAME OF HUSBAND OR WIFE DECEASED
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) NO	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT HOSPITAL RECORDS Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH 48 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerosis, generalized	
	DUE TO (c) 4500	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes, mellitus		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.)
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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
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21. I attended the deceased from <u>9-12-49</u> , to <u>8-23-58</u> and last saw her alive on <u>8-23-58</u> Death occurred at <u>10:30</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <i>Paul C. Minton</i> <u>M.D.</u>	22b. ADDRESS 1630 N. JEFFERSON SPRINGFIELD, MISSOURI	22c. DATE SIGNED <u>8-25-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8-25-58	23c. NAME OF CEMETERY OR CREMATORY GREENLAWN	23d. LOCATION (City, town, or country) (State) SPRINGFIELD, MISSOURI
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24. FUNERAL DIRECTOR <i>J. Klingner & Co.</i>	ADDRESS SPGFD. MO.	25. DATE RECD. BY LOCAL REG. <u>8-27-58</u>	26. REGISTRAR'S SIGNATURE <i>Effie S. Minton</i>
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(Licensed Embalmer's Statement on Reverse Side)

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 NATIONAL CENTER FOR HUMAN REPRODUCTION
 1230 MONTGOMERY AVENUE
 BETHESDA, MARYLAND 20814
 (301) 251-2541

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*
 409

Licensed Embalmer No.
 P. O. Address

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.