

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012921

STATE FILE NUMBER

FILED APR 27 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 411

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Springfield 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 <u>2500 N. Summit</u>			Length of stay in lb <u>38 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>2500 N. Summit</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Jim</u> Middle <u>P.</u> Last <u>Brust</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1959</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIAGE STATUS NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 18, 1893</u>		9. AGE (In years last birthday) <u>65</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (City and state or country) <u>Geneva, Nebraska</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				
13a. FATHER'S NAME <u>W. H. Brust</u>				13b. MOTHER'S MAIDEN NAME <u>Alice Davis</u>				14. NAME OF HUSBAND OR WIFE <u>Mary Brust</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give branch of service) <u>yes world war I</u>				16. SOCIAL SECURITY NO. <u>500-09-8307</u>		17. INFORMANT Address <u>Mary Brust Springfield, Missouri</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Circulatory Failure</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Thrombosis with Myocardial Infarction</u>										DUE TO (c) <u>Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4281</u>										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 <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> a.m. <u> </u> p.m. <u> </u>													
20d. INJURY OCCURRED WHILE AT WORK <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 <u>March 2, 1959</u> to <u>April 20, 1959</u> and last saw her alive on <u>April 14, 1959</u> Death occurred at <u>9:30 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Ray West D.D.</u> (Degree optional)						22b. ADDRESS <u>2432 Commercial, Springfield, Mo.</u>			22c. DATE SIGNED <u>4/21/59</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)					
<u>Burial</u>			<u>4-24-1959</u>		<u>Springfield National</u>			<u>Springfield Missouri</u>					
24. FUNERAL DIRECTOR <u>Rex Rainey Springfield, Mo.</u>						25. DATE RECD. BY LOCAL REG. <u>4-22-59</u>		26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>					

(Licensed Embalmers Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

FEB 21 1962

APR 20 1958

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 *Ray James* _____

Licensed Embalmer No. 3312 _____

P. O. Address Springfield, Mo _____

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.