

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028703

FILED VS SEP 8 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 902A

STATE FILE NUMBER

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|-------|--|--|----------------|--|
| 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 | | Length of stay in 1b 12 years | | c. CITY OR TOWN Springfield | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Handley Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 1038 E. Harrison | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) GERTRUDE L. BROCKMAN | | | | 4. DATE OF DEATH Month August Day 24 Year 1959 | | | | | | | | | |
| 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 July 3, 1863 | | 9. AGE (last birthday) 96 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HR | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY In Home | | | | 11. BIRTHPLACE (City and state or country) Cleveland, Ohio | | 12. CITIZEN OF WHAT COUNTRY USA | | | |
| 13a. FATHER'S NAME James E. Green | | | | 13b. MOTHER'S MAIDEN NAME Catherine Cook | | | | 14. NAME OF HUSBAND OR WIFE | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Ray R. Davis | | Address Springfield, Mo. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia | | | | | | | | | | 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) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| 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 a.m. p.m. | | Month, Day, Year | | | | | | | | | | | |
| 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>Aug 24</u> , to <u>Aug 24, 1959</u> and last saw her alive on <u>Aug 24, 1959</u> Death occurred at <u>6:00 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE <i>Rayman H. Brown M.D.</i> (Degree or title) | | | | 22b. ADDRESS <i>311 1/2 College</i> | | | | 22c. DATE SIGNED <i>9/3/59</i> (Style) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Aug. 26, 1959 | | 23c. NAME OF CEMETERY OR CREMATORY Maple Park | | 23d. LOCATION (city, town, or county) Springfield, Missouri | | | | | | | |
| 24. FUNERAL DIRECTOR Gorman-Scharpf Funeral Home Springfield, Missouri | | | | 25. DATE RECD. BY LOCAL REG. 9-3-59 | | 26. REGISTRAR'S SIGNATURE <i>Effie G. Melton</i> | | | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Leahui Gorman

Licensed Embalmer No. 3177

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.

Dr David L...