RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–031968

FILED VS OCT 13 1959

STATE FILE NUMBER

Registration District No. 728 Primary Registration District No. 2000 Registrar's No. 1065

DED

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Springfield — Length of stay in 1b: 4 months
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 911 N. Main — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Kansas b. COUNTY: Cherokee
c. CITY OR TOWN: Baxter Springs — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 624 Grant Ave — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: MAMIE Middle: BELL Last: BROWN
4. DATE OF DEATH: Month: October Day: 8 Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: Nov 26, 1880
9. AGE (last birthday): 78
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: 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: Own Home
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: (unknown) Phillips
13b. MOTHER'S MAIDEN NAME: (Unknown)(Slavens
14. NAME OF HUSBAND OR WIFE: --
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Sanford A. Jones, Springfield, Mo. Address

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) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis — 6 yrs
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. ☐ Yes ☐ No ☐ Unknown

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 Feb 20, 1959 to Oct 8, 1959 and last saw her/him alive on Oct 3, 1959
Death occurred at 8:05 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): G O Callaway Jr MD
22b. ADDRESS: Springfield, Mo
22c. DATE SIGNED: 10/8/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Oct. 8, 1959
23c. NAME OF CEMETERY OR CREMATORY: Unknown
23d. LOCATION (City, town, or county) (State): Baxter Springs, Kansas

24. FUNERAL DIRECTOR: Jewell E. Windle B.W. ADDRESS: Springfield, Mo.
25. DATE RECD. BY LOCAL REG.: 10-8-59
26. REGISTRAR'S SIGNATURE: Effie G. Mellon

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed Bernard F. Wr

Signature of Student Embalmer

Licensed Embalmer No. 429

P. O. Address Springf

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