

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-039622**

FILED VS. NOV 23 1959 128

128

Registration District No. \_\_\_\_\_ Primary Registration District No. 2000

Registrar's No. 1209A

STATE FILE NUMBER

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Greene</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> Length of stay in 1b <u>2 wks.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Johns Hosp</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u> c. CITY OR TOWN <u>Everton</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>R.F.D.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Washington</u> Middle <u>M.</u> Last <u>Britain</u>				<b>4. DATE OF DEATH</b> Month <u>NOV</u> Day <u>8</u> Year <u>1959</u>									
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>6-30-1879</u>		<b>9. AGE (last birthday)</b> <u>82</u>		<b>IF UNDER 1 YEAR</b> Months <u>4</u> Days <u>9</u> Hours <u></u> Min. <u></u>		<b>IF UNDER 24 HR</b> Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, or if retired) <u>Retired Doctor</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Republic-ino</u>				<b>11. BIRTHPLACE</b> (City and state or country) <u>USA</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>			
<b>13a. FATHER'S NAME</b> <u>George W. Britain</u>				<b>13b. MOTHER'S MAIDEN NAME</b> <u>Luecy Cox</u>				<b>14. NAME OF HUSBAND OR WIFE</b> <u>Barbara Britain</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>None</u>				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>William Britain</u> Address <u>Everton Mo.</u>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, general</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>BRONCHITIS, CHRONIC AND OBSTRUCTIVE PULMONARY EMPHYSEMA</u>										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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____													
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>					
<b>21. I attended the deceased from</b> <u>9-25</u> <u>11/8/52</u> to <u>11/8/59</u> and last saw <u>him</u> alive on <u>11/8/59</u> Death occurred at <u>8</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22a. SIGNATURE</b> (Degree or title) <u>Glenn O. Turner M.D.</u>						<b>22b. ADDRESS</b> <u>Springfield Mo.</u>				<b>22c. DATE SIGNED</b> <u>11/10/59</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>11-11-59</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Wade Chapel</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>N.W. of Republic Mo.</u>							
<b>24. FUNERAL DIRECTOR</b> <u>Morris Heiman</u> Address <u>Miller Mo.</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>11-17-59</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Effie S. Mellon</u>							

(Licensed Embalmer's Statement on Reverse Side)

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 m

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed



Licensed Embalmer No. 3297

P. O. Address Miller M

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.