

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039629

STATE FILE NUMBER

FILED VS NOV 3 0 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1271

ENDED

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		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 Burge Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1151 E. Chestnut		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First RUBY Middle L. Last BUFF				4. DATE OF DEATH Month November Day 24 Year 1959					
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1 Feb. 1920	9. AGE (last birthday) 39	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ 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 Home		11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME James W. Shelton			13b. MOTHER'S MAIDEN NAME Laura Copeland			14. NAME OF HUSBAND OR WIFE Vernon Buff			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Hospital Records				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor pulmonale							INTERVAL BETWEEN ONSET AND DEATH 6 mo.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pulmonary fibrosis							4 yrs.		
DUE TO (c) Bronchiectasis & bronchitis, chr.							yr.		
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 checked="" type="checkbox"/> NO <input 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>1955</u> to <u>11/24/59</u> and last saw her <u>alive</u> on <u>11/24/59</u> Death occurred at <u>11:45</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>Samuel E. Inatt, M.D.</i>				22b. ADDRESS 1630 N. Jefferson Springfield, Missouri				22c. DATE SIGNED 24 Nov 59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/27/59	23c. NAME OF CEMETERY OR CREMATORY Greenlawn		23d. LOCATION (City, town, or county) (State) Springfield, Missouri				
24. FUNERAL DIRECTOR ADDRESS KLINGNER MORTUARY, INC. SPRINGFIELD Jhc				25. DATE RECD. BY LOCAL REG. 11-27-59		26. REGISTRAR'S SIGNATURE <i>Effie S. Meets</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. 590

working under my personal supervision.

Student

John Klugner Jr
Signature of Student Embalmer

Signed

Max Hood

Licensed Embalmer No.

4071

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.