

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

'59 0 4 3 8 7 6

STATE FILE NUMBER

FILED VS DEC 28 1959

Registration District No. 128

Primary Registration District No. 200

Registrar's No. 1361A

5. 300
ev. 1-57

securing the medical certification in the specific manner required by 193.140 RSMOS 1949.
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
 All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

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		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Republic		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		Length of stay in lb 1 day.	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Clarence Middle Emmett Last Berridge			4. DATE OF DEATH Month December Day 14 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-22-1881	9. AGE (In years at birthday) 78	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and state or country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME James Berridge		13b. MOTHER'S MAIDEN NAME (unknown) Carter		14. NAME OF HUSBAND OR WIFE Elsie Thorton	
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 Address Mrs. Betty White Witchata, Kans		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Disease					INTERVAL BETWEEN ONSET AND DEATH 5 hrs.
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)					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.) 1221		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from December 14, 1959 Dec. 14, 1959 and last saw him alive on December 14, 1959 Death occurred at 3:55 P.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Name or title) Lyman D. Brown M.D.			22b. ADDRESS 31 1/2 College		22c. DATE SIGNED 12/22/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-17-1959	23c. NAME OF CEMETERY OR CREMATORY Wise Hill Cemetery		23d. LOCATION (City, town, or county) (State) Clever, Mo.	
24. FUNERAL DIRECTOR W.B. Cantrell Republic, Mo.			25. DATE RECD. BY LOCAL REG. 12-23-59	26. REGISTRAR'S SIGNATURE Effie S. Melton	

JAN 14 1960

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 *William B. Cantel*

Licensed Embalmer No. *4820*
P. O. Address *Capaldi, Md.*

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.