

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038000

FILED VS NOV 14 1960

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1106

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>GREENE</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		Length of stay in 1b <u>5 WKS.</u>		c. CITY OR TOWN <u>SPRINGFIELD</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BURGE Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>222 N GRANT</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUSSELL MOSES BLEVINS</u>				4. DATE OF DEATH Month Day Year <u>NOV-3-1960</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1-6-1892</u>			
9. AGE (last birthday) <u>68</u>		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) <u>RETIRED FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>WRIGHT Co. MO</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>				
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			13a. FATHER'S NAME <u>JOHN W. BLEVINS</u>		13b. MOTHER'S MAIDEN NAME <u>FRANCES MEEK</u>		14. NAME OF HUSBAND OR WIFE <u>BESSIE BLEVINS</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>491-12-783</u>		17. INFORMANT <u>Bessie Blevins</u> Address <u>222 N Grant Springfield, Mo</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe diffuse brain injury due to trauma</u>							INTERVAL BETWEEN ONSET AND DEATH <u>37 days</u>		
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) <u>Severe compound comminuted fracture left tibia/fibula</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				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) <u>Struck by auto</u>					
20c. TIME OF INJURY Hour <u>7:15</u> Month, Day, Year <u>Sept 27 '60</u> p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. CITY, TOWN, OR LOCATION <u>Springfield</u>		COUNTY <u>Greene</u> STATE <u>Mo.</u>	
21. I attended the deceased from <u>Sept 27, 1960</u> to <u>Nov 3, 1960</u> and last saw her/him alive on <u>Nov 2, 1960</u> Death occurred at <u>4:00 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Frank A. Sundstrom M.D.</u>				22b. ADDRESS <u>Springfield, Mo.</u>				22c. DATE SIGNED <u>11-4-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>11-6-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SEYMOUR Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>WEBSTER Co. Mo.</u>		
24. FUNERAL DIRECTOR <u>Robert Bergman Seymour, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>11-7-60</u>		26. REGISTRAR'S SIGNATURE <u>Effie G. Meelen</u>			

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 Max L Miller

Licensed Embalmer No. 4720

P. O. Address Manoquid

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