

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-028965
STATE FILE NUMBER

AMENDED

Registration District No. 128 Primary Registration District No. _____ Registrar's No. _____

FILED AUG 23 1961

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| 1. PLACE OF DEATH a. COUNTY Greene | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Greene | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Greene Co' R F D 4 | | c. CITY OR TOWN Springfield | |
| Length of stay in 1b 1 month | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Sunshine Acres Hospt | | d. STREET ADDRESS (If outside, give location) 617 N Benton Ave' | |
| Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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|--|--|--|---|--|--|--|
| 3. NAME OF DECEASED (Type or print) First STELLA Middle _____ Last SIMS | | | 4. DATE OF DEATH Month Aug Day 10 Year 1961 | | | |
|--|--|--|---|--|--|--|

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|----------------------|-------------------------------|---|--------------------------------------|----------------------------------|--|--|
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Aug '12 1874 | 9. AGE (last birthday) 86 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
|----------------------|-------------------------------|---|--------------------------------------|----------------------------------|--|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Strafford Mo' | 12. CITIZEN OF WHAT COUNTRY USA |
|---|-----------------------------------|---|--|

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|---|---|---|
| 13a. FATHER'S NAME George Crittenden | 13b. MOTHER'S MAIDEN NAME Eliza Bedell | 14. NAME OF HUSBAND OR WIFE None |
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|--|-------------------------|--|---------|
| 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. | 17. INFORMANT Margie Little 617 N Benton Ave' | Address |
|--|-------------------------|--|---------|

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cardio-Renal Disease | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Diabetic Gangrene | | |
| DUE TO (c) | | |

| | | | |
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| 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 | |
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| 19. WAS AUTOPSY PERFORMED? YES <input 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year |
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| | | | | |
|--|--|------------------------------|--------|-------|
| 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 1951 to Aug 10, 1961 and last saw her alive on Aug. 2, 1961
Death occurred at 4:10a m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) Lyman W. Brown M.D. | 22b. ADDRESS 311 1/2 College | 22c. DATE SIGNED 8/14/61 |
|--|--|------------------------------------|

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|--|----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Aug '12 1961 | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial | 23d. LOCATION (City, town, or county) (State) Springfield Mo' |
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| | | |
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| 24. FUNERAL DIRECTOR H V Smith 602 N Jefferson St. | 25. DATE RECD. BY LOCAL REG. 8-21-61 | 26. REGISTRAR'S SIGNATURE Effie S. Melton |
|--|--|---|

Spide, Mo
(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

MAY 10 1962

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 Hubert V Smith

Licensed Embalmer No. 4286

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.