

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044319

MENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 128 Primary Registration District No. _____ Registrar's No. 1252

FILED DEC 26 1961

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</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>life</u>	c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sunshine Acres</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>828 South New</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>BERTIE E. TRIPLETT</u>			4. DATE OF DEATH Month Day Year <u>Dec. 13, 1961</u>		
---	--	--	--	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/23/80</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
-------------------------	----------------------------------	---	------------------------------------	-------------------------------------	---	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Greene Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
---	--	--	---

13a. FATHER'S NAME <u>Wm. J. Tillman</u>	13b. MOTHER'S MAIDEN NAME <u>Martha L. Tillmon</u>	14. NAME OF HUSBAND OR WIFE <u>Frank M. Triplett</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>None</u>	17. INFORMANT <u>Dr. Walter Tillman; Spfd., Mo.</u> 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) <u>Lobar Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</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>Generalized arteriosclerosis. Encephalo malacia</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
---	--	---

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.)
---	---	--

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>July, 1961</u> to <u>Present Time</u> and last saw her alive on <u>DEC. 10, 1961</u> Death occurred at <u>2:25</u> a. m on the date stated above, and to the best of my knowledge, from the causes stated.		
---	--	--

22a. SIGNATURE (Degree or title) <u>J. Richard Webb, M.D.</u>	22b. ADDRESS <u>Springfield, Missouri</u>	22c. DATE SIGNED
--	--	------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/14/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hazelwood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>
--	------------------------------	---	--

24. FUNERAL DIRECTOR <u>Ayre-Goodwin</u> ADDRESS <u>Springfield, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-19-61</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>
---	---	---

DATE AWENUE

INS HEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

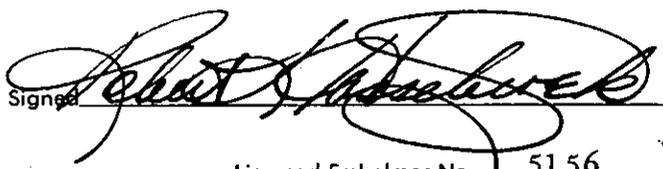
ITEM NO. SHOULD READ

Dr. W.
Mrs. B.

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 

Licensed Embalmer No. 5156

P. O. Address Springfield, Mo

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.