

FILED JAN 31 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 866

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>69</u>	
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>Texas</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (in this place) TOWNSHIP) <u>2</u> weeks		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cabool</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Baptist Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>No street address</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Susie</u>		b. (Middle) <u>Brauer</u>		c. (Last) <u>Ball</u>	
		4. DATE OF DEATH		(Month) <u>January</u>		(Day) <u>24</u> (Year) <u>1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>May 18, 1875</u>	
		9. AGE (In years last birthday) <u>73</u>		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) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Heye Brauer</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Gerdis</u>		14. NAME OF HUSBAND OR WIFE <u>---</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'S SIGNATURE OR NAME ADDRESS <u>Dena Erickson, Hillsboro, Oregon</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Auricular Fibrillation</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Toxic adenomatous goitre</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Diverticulitis, acute left colon with left inguinal abscess.</u> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>3</u> days <u>10</u> yrs.	
19a. DATE OF OPERATION <u>1-6-49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Incision and drainage left inguinal abscess</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>U</u>			
22. I hereby certify that I attended the deceased from <u>1-6-</u> , 19 <u>49</u> , to <u>1-24-49</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>1-24-</u> , 19 <u>49</u> , and that death occurred at <u>1:00</u> A.m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Fred R. Farthing M.D.</u>		(Degree or title)		23b. ADDRESS <u>Medical Arts Bldg., Springfield, Mo.</u>		23c. DATE SIGNED <u>1-24-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan 26, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Cabool Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Cabool Missouri</u>	
DATE REC'D BY LOCAL REG. <u>1-26-49</u>		REGISTRAR'S SIGNATURE <u>W. E. Handley M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Alma Lohmeyer Funeral Home, Springfield, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Signed _____

Jewell E. Skindler

Signed _____

Student Embalmer

Licensed Embalmer No. *2831*

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 this body is not embalmed, fact should be so stated above.