

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41260

State File No. ....

FILED DEC 31 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 1084

396  
0

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

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, write RURAL and give township) OR TOWN <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Galloway</u>	
c. LENGTH OF STAY (In this place) <u>2 days</u>		d. STREET ADDRESS (If rural, give location) <u>No street address</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Burge Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>GRACE</u>	b. (Middle) <u>BURKS</u>	c. (Last) <u>BRADEN</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>December 22 1951</u>
-------------------------------------	-------------------------	--------------------------	-------------------------	---

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 10, 1896</u>	9. AGE (In years last birthday) <u>55</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>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Webster Co., Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	---	--	--

13a. FATHER'S NAME <u>Bert Burks</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Frank Braden, Galloway, Mo.</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 <u>Frank Braden, Galloway, Missouri</u>	ADDRESS
--	-------------------------------------	---	---------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) <u>Cerebral hemorrhage</u>	DUE TO (b) <u>Arterial sclerosis</u>		<u>2 weeks</u>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c)		<u>months</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>331X</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?
--	--	----------------------------

22. I hereby certify that I attended the deceased from 12-17, 1951, to 12-22, 1951, that I last saw the deceased alive on 12-22, 1951, and that death occurred at 10:00A m., from the causes and on the date stated above.

23a. SIGNATURE <u>E. Allen Pacheco, M. D.</u>	(Degree or title)	23b. ADDRESS <u>407 Medical Arts Bg.</u>	23c. DATE SIGNED <u>12-24-51</u>
---	-------------------	--	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Dec 24, 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Greenhill Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Near Fordland, Missouri</u>
---	-------------------------------	--	--

DATE REC'D BY LOCAL REG. <u>12-26-51</u>	REGISTRAR'S SIGNATURE <u>Faith Williams</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Sahmeyer, Springfield, Mo</u>	ADDRESS
--	---	--	---------

(Licensed Embalmer's Statement on Reverse Side)

*Dr. Perkins  
med care*

**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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed Bernard F. Wright

Signed.....  
Student Embalmer

Licensed Embalmer No. 4293

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