

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **7478**

BIRTH NO. **FILED MAR 5 1954** REG. DIST. NO. **930** PRIMARY REG. DIST. NO. **6112A** Registrar's No. **2**

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

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Scott</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY <b>Scott</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Anzell</b> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Anzell 10<sup>th</sup></b>                                |  |
| c. LENGTH OF STAY (in this place) <b>1 month</b>   |  | d. STREET ADDRESS (If rural, give location)   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>at Elva Brant home</b>                          |  |   |  |

|  |                           |                          |                        |  |
|--|---------------------------|--------------------------|------------------------|--|
| 3. NAME OF DECEASED<br>(Type or Print) | a. (First) <b>BARBARA</b> | b. (Middle) <b>SUSAN</b> | c. (Last) <b>BRANT</b> | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><b>FEB 18 1954</b> |
|--|---------------------------|--------------------------|------------------------|--|

|                      |                               |   |                                       |   |                               |                                |
|----------------------|-------------------------------|---|---------------------------------------|---|-------------------------------|--------------------------------|
| 5. SEX <b>Female</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b> | 8. DATE OF BIRTH <b>Sept 13, 1886</b> | 9. AGE (in years last birthday) <b>77</b> | IF UNDER 1 YEAR<br>Month Days | IF UNDER 24 HRS.<br>Hours Min. |
|----------------------|-------------------------------|---|---------------------------------------|---|-------------------------------|--------------------------------|

|  |                                   |   |   |
|--|-----------------------------------|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <b>Mississippi County, Missouri</b> | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b> |
|--|-----------------------------------|---|---|

|                                      |   |  |
|--------------------------------------|---|--|
| 13a. FATHER'S NAME <b>Montgomery</b> | 13b. MOTHER'S MAIDEN NAME <b>Cecilia Louder</b> | 14. NAME OF HUSBAND OR WIFE <b>David Brant</b> |
|--------------------------------------|---|--|

|  |                                     |   |                           |
|--|-------------------------------------|---|---------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> | 16. SOCIAL SECURITY NO. <b>None</b> | 17. INFORMANT'S SIGNATURE OR NAME <b>Mrs Alfred Collier</b> | ADDRESS <b>Anzell, Mo</b> |
|--|-------------------------------------|---|---------------------------|

|   |  |  |   |
|---|--|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocardial failure</b>   |  | INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> |
|   | ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Cardiac decompensation</b> |  | <b>2 weeks</b>                                |
|   | DUE TO (c) <b>Renal failure</b>  |  |   |
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Cholysthis</b>   |  |  |   |

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input 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)<br><b>42225</b> |
|--|--|---|

|   |  |                            |
|---|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|---|--|----------------------------|

2. I hereby certify that I attended the deceased from **Oct 25, 1952** to **Feb 18, 1954**, that I last saw the deceased alive on **Feb 14, 1954**, and that death occurred at **8 P.M.**, from the causes and on the date stated above.

|  |   |                                      |
|--|---|--------------------------------------|
| 23a. SIGNATURE (Degree or title) <b>George W. England D.D.</b> | 23b. ADDRESS <b>4601. Main Cape Girardeau</b> | 23c. DATE SIGNED <b>Feb 22, 1954</b> |
|--|---|--------------------------------------|

|   |                          |  |   |
|---|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b> | 24b. DATE <b>2-21-54</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>Lightner Cemetery Illinois, Missouri</b> | 24d. LOCATION (City, town, or county) (State) |
|---|--------------------------|--|---|

|   |  |  |         |
|---|--|--|---------|
| DATE REC'D BY LOCAL REG. <b>Feb. 27</b> | REGISTRAR'S SIGNATURE <b>G. P. Dorris 1300-0</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Dupling-Hoff Funeral Home Illinois, Mo</b> | ADDRESS |
|---|--|--|---------|

Rec 3-2-54  
Scott Co. Health Dept.  
File No 354-53

**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 .....  
Student Embalmer

Signed \_\_\_\_\_

*Oliver Amick*

Licensed Embalmer No. 4470

P. O. Address Illmo, 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.