

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

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

FILED MAR 26 1954 REG. DIST. NO. **132** PRIMARY REG. DIST. NO. **3021** Registrar's No. **49**

1. PLACE OF DEATH a. COUNTY Grundy		2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission). a. STATE Missouri b. COUNTY Darless	
b. CITY (If outside corporate limits, write RURAL and give township) Wrenton		c. CITY (If outside corporate limits, write RURAL and give township) Rock Springs 0310	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lycans' nursing home Wrenton, Mo.		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or Print) SARAH ANN BROOKSHIRE		4. DATE OF DEATH (Month) (Day) (Year) Mar. 19 1954	
5. SEX F	6. COLOR OR RACE W	7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 16, 1867
9. AGE (In years last birthday) 86		10. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and State or Foreign Country) Livingston Co. Missouri
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Thomas Letton		13b. MOTHER'S MAIDEN NAME Nancy Barnes	
14. NAME OF HUSBAND OR WIFE Mrs. Osa Lypson, Phillips Mo.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mrs. Osa Lypson, Phillips Mo.	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio Sclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) 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 1500	
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) (Min.)		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 <u>Jan 25, 1953</u>, to <u>Mar 19, 1954</u>, that I last saw the deceased alive on <u>Mar 18, 1954</u>, and that death occurred at <u>10:30</u> m., from the causes and on the date stated above.			
23a. SIGNATURE E. A. Deffy M.D.		23b. ADDRESS Wrenton Mo	
23c. DATE SIGNED Mar 22			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Mar. 21-1954	
24c. NAME OF CEMETERY OR CREMATORY Rock Springs Cemetery		24d. LOCATION (City, town, or county) (State) Rock Springs Mo.	
DATE REC'D BY LOCAL REG. 3-21-1954		REGISTRAR'S SIGNATURE Irene Jaw	
25. FUNERAL DIRECTOR'S SIGNATURE J. E. Roberson		ADDRESS Jefferson Mo	

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

J. L. Baberson

Licensed Embalmer No. *3244*

P. O. Address *Jamesport, Md.*

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.