

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **33660**

FILED NOV 15 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5460 Registrar's No. 1036

1. PLACE OF DEATH a. COUNTY <u>Green</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Green</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Galloway, Clay Township</u>		c. LENGTH OF STAY (in this place) <u>13 Wks.</u>	c. CITY OR TOWN <u>Galloway</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Rural Route</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
		e. STREET ADDRESS (If rural, give location) <u>0390 Green</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Frank</u>	b. (Middle) <u>J.</u>	c. (Last) <u>Braden</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 9, 1954</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 25, 1896</u>	9. AGE (In years last birthday) <u>58</u>	IF UNDER 1 YEAR Months	IF UNDER 11 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Wm. Braden</u>	13b. MOTHER'S MAIDEN NAME <u>Rosie Bounds</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW I</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Edith Daniels, Sparta, Mo.</u>	ADDRESS
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Probable Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
	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.		

UNATTENDED BY A PHYSICIAN 4/201

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at about 5:00 A.M., from the causes and on the date stated above.

23. SIGNATURE <u>Edith Daniels</u> Local Registrar (Degree or title) Vital Statistics	23b. ADDRESS <u>Greene County Court House, Springfield, Missouri</u>	23c. DATE SIGNED <u>11/10/54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Nov. 12-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Armore Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Columbia County, Mo</u>
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DATE REC'D BY LOCAL REG. <u>11/10/54</u>	REGISTRAR'S SIGNATURE <u>Edith Daniels</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>T. B. Chaffin</u>	ADDRESS <u>Ozark, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0340

NOV 16 1954

NOV 23 1954

NOV 23 1954

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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..... *F. B. Chaffin*

Licensed Embalmer No. *219*

P. O. Address..... *Dyck*

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.