

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7730

State File No. \_\_\_\_\_

FILED MAR 2 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 933 PRIMARY REG. DIST. NO. 3074 Registrar's No. 34

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Sikeston</u>		c. LENGTH OF STAY (in this place) <u>4 1/2 hrs.</u>	c. CITY OR TOWN <u>Bell City</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Delta Community Hospital</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
STREET ADDRESS (If rural, give location) <u>Rt. # 1</u>		<u>10001</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Hugh</u>	b. (Middle) <u>Benton</u>	c. (Last) <u>Brasell</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>2-22-1956</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>Married</u>	8. DATE OF BIRTH <u>4-6-1895</u>	9. AGE (In years last birthday) <u>60</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Reynolds County, Mississippi</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Hugh B. Brasell</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Louise Kirkwood</u>	14. NAME OF HUSBAND OR WIFE <u>Mary Elizabeth Hill Brasell</u>
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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 ADDRESS <u>Mary Elizabeth Brasell, Bell City, Mo.</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial infarction</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.			

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) <u>4201</u>
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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 2-21, 1956, to 2-22, 1956, that I last saw the deceased alive on 2-22, 1956, and that death occurred at 2:55 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Alfred J. Dargent MD</u> (Degree or title) _____	23b. ADDRESS <u>707 Tanner, Sikeston, Mo.</u>	23c. DATE SIGNED <u>2-22-56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	24b. DATE <u>2-23-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Collierville, Tennessee</u>
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DATE REC'D BY LOCAL REG. <u>2-22-56</u>	REGISTRAR'S SIGNATURE <u>Miss E. Hunter</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Welch Funeral Home - Sikeston Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB 27 1956

DATE RECEIVED \_\_\_\_\_

SCOTT CO. HEALTH DEPT.

CO. FILE No. 256-50

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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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Leicester

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.