

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **21699**
Registrar's No. **5543**

FILED JUN 20 1956

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY ST LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY Madison	
b. CITY (If outside corporate limits, write RURAL and give town) ST LOUIS		c. CITY OR TOWN Collinsville	
c. LENGTH OF STAY (in this place) 11 Days		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hosp.		e. STREET ADDRESS (If rural, give location) 324 Sycamore Street 8128	
3. NAME OF DECEASED a. (First) VERNON		b. (Middle) H.	
c. (Last) BRAYFORD		4. DATE OF DEATH (Month) (Day) (Year) JUNE 11, 1956	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH MAY 7, 1910	
9. AGE (In years last birthday) 46		IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 1 HR. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) First Aid Dept.		10b. KIND OF BUSINESS OR INDUSTRY Paint MFG Co.	
11. BIRTHPLACE (City and State or Foreign Country) COLLINSVILLE, ILL		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME WM BRAYFORD		13b. MOTHER'S MAIDEN NAME (Unknown) KRIEDER	
14. NAME OF HUSBAND OR WIFE BEULAH BRAYFORD		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II	
16. SOCIAL SECURITY NO. 343-10-8531		17. INFORMANT'S SIGNATURE OR NAME Beulah Brayford ADDRESS 324 Sycamore ST	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bacterial Pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Respiratory Failure DUE TO (c) Guillaine-Barre Syndrome	
INTERVAL BETWEEN ONSET AND DEATH 1 day		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION 6-9-56		19b. MAJOR FINDINGS OF OPERATION trauma	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		364 X	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, etc.) _____	
21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____	
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 6-1-1956 , to 6-11-1956 , that I last saw the deceased alive on 6-11-1956 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE Joseph E. Carney M.D. (Degree or title)		23b. ADDRESS 906 Olive	
23c. DATE SIGNED 6-11-56		24. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 6-14-56		24c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY	
24d. LOCATION (City, town, or county) (State) COLLINSVILLE, ILL.		25. FUNERAL DIRECTOR'S SIGNATURE Paul E. Troeman ADDRESS 314 W. 7th	
DATE REC'D BY LOCAL REG. JUN 11 1956		REGISTRAR'S SIGNATURE Paul Smith M.D.	

(Licensed Embalmer's Statement on Reverse Side)

Collinsville, Ill.

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

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 *Paul E. Loman*.....

Licensed Embalmer No. *7808*.....

P. O. Address *314 W. Ma Collins*.....

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.