

FILED NOV 1 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

33812

Registration District No. 144 Primary Registration District No. 4233 Registrar's No. 92

1. PLACE OF DEATH a. COUNTY <u>Iron</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Iron</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Arcadia</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Arcadia</u> <u>0470</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Glen Ayre Manor</u> Length of stay in 1b <u>1 yr</u>		d. STREET ADDRESS (If outside, give location) <u>1en Ayre Manor</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>J.</u> Last <u>BRANDON</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>16</u> Year <u>1956</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Mar 25 1870</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>unknown</u>			14. MOTHER'S MAIDEN NAME <u>unknown</u>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>542-20-0415</u>	17. INFORMANT <u>Iron Co. Welfare Office, Ironton</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>Generalized ARTERIOSCLEROSIS</u> <u>years?</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <u>332X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from <u>OCT 14 '56</u> to <u>OCT 16 '56</u> and last saw <u>him</u> alive on <u>OCT 14 '56</u> Death occurred at <u>1:30</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Marvin C. Menne, M.D.</u>	22b. ADDRESS <u>Ironton, Mo.</u>	22c. DATE SIGNED <u>10-18-56</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10-19-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARCADIA VALLEY MEM. PARK IRONTON MO</u>	23d. LOCATION (City, town, or county) (State) <u>IRONTON MO</u>
24. FUNERAL DIRECTOR <u>White Funeral Home, Ironton Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-20-56</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Aris Jones</u>

Ardis White
(Licensed Embalmer's Statement on Reverse Side)

300
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

MEDICAL CERTIFICATION

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.....

Licensed Embalmer No. 429

P. O. Address.....

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.