

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7636**

FILED APR 8 - 1957

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **338**

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

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY OR TOWN Dearborn, Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		e. STREET ADDRESS (If rural, give location) R.F.D #1	
3. NAME OF DECEASED a. (First) Dorothy		b. (Middle) Mae	
c. (Last) Brinton		4. DATE OF DEATH (Month) (Day) (Year) March 18 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Aug. 10, 1955
9. AGE (In years last birthday) 1		10. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and State or Foreign Country) St. Joseph, Mo.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		12. CITIZEN OF WHAT COUNTRY? USA.	
13a. FATHER'S NAME Harold Brinton		13b. MOTHER'S MAIDEN NAME Saramae Utter	
14. NAME OF HUSBAND OR WIFE Never Married		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Harold Brinton ADDRESS Dearborn, 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) MYOCARDIAL FAILURE ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) CONGENITAL HEART DISEASE 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? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7544	
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)	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 8/10/55 to 8/18/57 , that I last saw the deceased alive on 8/18/57 , 19 57 , and that death occurred at 8 Am. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) H. W. Waechter M.D.		23b. ADDRESS St. Joseph, Mo.	
23c. DATE SIGNED MAR. 28, 1957			
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 3/19/1957	24c. NAME OF CEMETERY OR CREMATORY Agency Cemetery	24d. LOCATION (City, town, or county) (State) Agency Mo.
DATE REC'D BY LOCAL REG. April 1, 1957	REGISTRAR'S SIGNATURE Becher M.	FUNERAL DIRECTOR'S SIGNATURE John H. Murray Lower Mo. ADDRESS	

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 *Me*....., Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *John H. Murray*.....

Licensed Embalmer No. *289*

P. O. Address *Gower*

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.