Health, Welfare Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

WASH BARN

FILED OCT 15 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

32740
STATE FILE NUMBER

Registration District No. 236 Primary Registration District No. 4351 Registrar's No. 70

1. PLACE OF DEATH
a. COUNTY: MORGAN
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: BARNETT — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: MORGAN
c. CITY OR TOWN: BARNETT — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First JOSEPHINE Middle BROOKS Last DUNSTAN
4. DATE OF DEATH: Month Oct. Day 9 Year 1957
5. SEX: FEMALE
6. COLOR OR RACE: CAUCASIAN
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JUNE 3, 1887
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Rocky Mt. Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: MARTIN McCONNELL
14. MOTHER'S MAIDEN NAME: UNKNOWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 499-24-9369
17. INFORMANT: Bennett Dunstan Address: Barnett, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Repeated Myocardial Infarction — 10 mo.
DUE TO (c): Coronary Insufficiency — ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 4201
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Dec. 20, 1956 to Oct 9, 1957 and last saw her alive on Oct 7, 1957
Death occurred at 5 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: J L Washburn (Degree or title) M.D.
22b. ADDRESS: Versailles Mo
22c. DATE SIGNED: 10/10/57

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: Oct. 11, 1957
23c. NAME OF CEMETERY OR CREMATORY: Dooley
23d. LOCATION (City, town, or county) (State): Eldon Mo.
24. FUNERAL DIRECTOR: Louis W. Phillips ADDRESS: Eldon Mo
25. DATE RECD. BY LOCAL REG.: 10/10/57
26. REGISTRAR'S SIGNATURE: J L Washburn M.D.

(Licensed Embalmer's Statement on Reverse Side)

14-

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Louis W. Phillips

Licensed Embalmer No. 34

P. O. Address Eld

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (I
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.