

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED DEC 11 1957

Registration District No. 13 Primary Registration District No. 3003 Registrar's No. 9

S. 300  
ov. 1-57

1. PLACE OF DEATH a. COUNTY <u>Barry</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stone</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Manell</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Crane</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF <del>NOT</del> IN hospital, give location) HOSPITAL OR INSTITUTION <u>St. Vincent</u>			Length of stay in lb <u>9 wks</u>		d. STREET ADDRESS (If outside, give location) <u>1240</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Oscar</u> Middle <u>Bonnie</u> Last <u>Brink</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>28</u> Year <u>1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 15 - 1876</u>		9. AGE (In years last birthday) <u>81</u> FUNDER 1 YEAR Months Days Hours IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13a. FATHER'S NAME <u>Joe Brink</u>				13b. MOTHER'S MAIDEN NAME <u>Jude Glenn</u>			14. NAME OF HUSBAND OR WIFE		
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. <u>495-09-8018</u>		17. INFORMANT Address <u>Miss Anna Winters Heavath, Kansas</u>			
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 occlusion</u> <u>Subarachnoid hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>4201</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Disclinal ulcer &amp; heart failure by stroke</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 _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____									
20d. INJURY OCCURRED WHILE AT <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>Sept 29 '57</u> to <u>Nov 28 '57</u> and last saw him alive on <u>Nov 25 '57</u> Death occurred at <u>10:45 PM</u> <u>10:45 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Robert H. Woodley M.D.</u> (Degree or title)					22b. ADDRESS <u>Wright, Mo.</u>			22c. DATE SIGNED <u>11-29-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>11/28/57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mass Ridge Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Carthage, Ill</u>		
24. FUNERAL DIRECTOR <u>George H. Manlove</u>			ADDRESS <u>Crane, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-2-57</u>		26. REGISTRAR'S SIGNATURE <u>Mr. P. H. Cook</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

NO. 1257-221

DATE REC. 12-9-57

DEC 12 1957  
DEC 13 1957

JAN 17 1958  
MAR 3 1958

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 George H. Mauldin

Licensed Embalmer No. 3827

P. O. Address Oran, Mo.

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.