

FILED DEC 3 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40960

STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 113

0542
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1-57

1. PLACE OF DEATH a. COUNTY <u>LAFAYETTE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LAFAYETTE</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LEXINGTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>CONCORDIA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MEMORIAL HOSPITAL</u>		Length of stay in lb <u>7 Days</u>	d. STREET ADDRESS (If outside, give location) <u>307 Main St</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>FREDA</u> Middle <u>LEONA</u> Last <u>BRUNS</u>			4. DATE OF DEATH Month <u>NOV</u> Day <u>24</u> Year <u>1957</u>		
5. SEX <u>FEMALE</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>OCT 21, 1891</u>	9. AGE (In years last birthday) <u>66</u> 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) <u>RETIRED FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GEN. FARMING</u>	11. BIRTHPLACE (City and state or country) <u>CONCORDIA, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13a. FATHER'S NAME <u>WILLIAM H BRUNS</u>		13b. MOTHER'S MAIDEN NAME <u>SOPHIE ROSENKOH</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</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>NO</u>	17. INFORMANT Address <u>MRS WALTER ROSEPE OKLAHOMA CITY, OKLA.</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>Hepato-renal failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>48 mos</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Carcinoma of breast with generalized metastases</u>			DUE TO (c) <u>170X</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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 <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>July 1957</u> to <u>Nov 24, 1957</u> and last saw her alive on <u>Nov 23, 1957</u> Death occurred at <u>12:30</u> A. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>H. Brady M.D.</u> (Degree or title)			22b. ADDRESS <u>Concordia, Missouri</u>		22c. DATE SIGNED <u>11/24/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>Nov. 26, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL'S</u>		23d. LOCATION (City, town, or county) (State) <u>CONCORDIA, MO</u>
24. FUNERAL DIRECTOR <u>E. S. James</u>		ADDRESS <u>Concordia, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4-20-57</u>	26. REGISTRAR'S SIGNATURE <u>Missouri State Registrar</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.

FEB 19 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 Mr....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed E. S. James.....

Licensed Embalmer No. 2058.....

P. O. Address Columbia 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.