

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1821
STATE FILE NUMBER

FILED FEB 13 1958

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 9

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>Lexington</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>312 North 15th St.</u>			Length of stay in lb <u>40 years</u>		
d. STREET ADDRESS <u>312 North 15th St.</u>			(If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>AARON ADOLPHICE BROOKS</u>			4. DATE OF DEATH Month Day Year <u>January 10 1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14 1881</u>		9. AGE (In years last birthday) <u>76</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Constuction</u>	11. BIRTHPLACE (City and state or country) <u>Lamonte, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John R. Brooks</u>			14. MOTHER'S MAIDEN NAME <u>Dell Watson</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>none</u>	17. INFORMANT Address <u>Guy Brooks, Lexington, Missouri</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>Bronchial pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coronary heart disease. Arteriosclerosis</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. Month, Day, Year					
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>1/9/58</u> to <u>1/10/58</u> and last saw ^{her} him alive on <u>1/10/58</u> Death occurred at <u>1:45 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Ben H. Brasher M.D.</u>			22b. ADDRESS <u>Lexington, Mo.</u>		22c. DATE SIGNED <u>1/18/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan. 12, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wachpelah</u>		23d. LOCATION (City, town, or county) (State) <u>Lexington Missouri</u>	
24. FUNERAL DIRECTOR <u>Joseph T. Feys Lexington, Missouri</u>			25. DATE RECD. BY LOCAL REG. <u>2-4-58</u>		26. REGISTRAR'S SIGNATURE <u>Wm. S. Gualtieri</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health, welfare, public service, 000-56, Doctor, coroner, etc. must use only standard nomenclature in name to no symptoms with no natural causes. Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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.....
J. L. McKean

Licensed Embalmer No.
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P. O. Address.....
Terre Haute, Ind.

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