

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-031975

STATE FILE NUMBER

FILED SEP 22 1958

Registration District No. 53 Primary Registration District No. \_\_\_\_\_ Registrar's No. 458

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>CAPE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>CAPE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CAPE GIRARDEAU</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>CAPE GIRARDEAU</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>601<sup>R</sup> GOOD HOPE ST.</u>		Length of stay in 1b <u>4 YRS.</u>	d. STREET ADDRESS (If outside, give location) <u>601<sup>R</sup> GOOD HOPE ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES PAUL BRUMBLEY</u>			4. DATE OF DEATH Month Day Year <u>SEPT. 11 1958</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 31 1917</u>
9. AGE (In years last birthday) <u>40</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>8 10</u>	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECTION WORKER (RET.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GREAT NORTHERN P.R.</u>	11. BIRTHPLACE (City and state or country) <u>CHAFFEE, MISSOURI</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>JAMES R. BRUMBLEY</u>	
13b. MOTHER'S MAIDEN NAME <u>LUBA B. CAMERON</u>		14. NAME OF HUSBAND OR WIFE <u>MARGIE COFFEY BRUMBLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WHITE</u>		16. SOCIAL SECURITY NO. <u>723-05-1388</u>	17. INFORMANT Address <u>MRS. FRED MAMMON - CHAFFEE, Mo.</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>Exsanguination</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hemorrhage - Intestinal</u>			—
DUE TO (c) <u>Ruptured Aortic Aneurysm</u>			—
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Epilepsy + alcoholism</u>			19. WAS AUTOPSY PERFORMED? 1 YES <input checked="" type="checkbox"/> NO <input 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 _____, to _____ and last saw her/him alive on _____ Death occurred at <u>7:00 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>G. H. Johnson, M.D. (Coroner)</u>		22b. ADDRESS <u>Cape Girardeau, Mo.</u>	
22c. DATE SIGNED <u>9/15/58</u>		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>SEPT. 15, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>JEFFERSON BARRS. NATIONAL Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>JEFFERSON BARRACKS, MISSOURI</u>
24. FUNERAL DIRECTOR <u>BISPLINGHOFF FUNERAL HOME - CHAFFEE, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Sept. 15, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. James Cooper</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

SEP 24 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 *Jack T. Lurnett* .....  
Licensed Embalmer No. *4473* .....

P. O. Address. *Chaffee, 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.