

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043358

STATE FILE NUMBER

FILED JAN 8 1958 Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 718

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| 1. PLACE OF DEATH a. COUNTY Stoddard <u>Butler</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Poplar Bluff</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>1030</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Poplar Bluff Hosp</u> | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) <u>Purice Mo R-1-</u> |
| | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First <u>Sam</u> Middle <u>—</u> Last <u>Brimm</u> | | | 4. DATE OF DEATH Month <u>oct</u> Day <u>20</u> Year <u>1958</u> | | |
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| 5. SEX <u>m</u> | 6. COLOR OR RACE <u>w</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>Jan 11 1909</u> | 9. AGE (In years last birthday) <u>49</u> | IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> | IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | 11. BIRTHPLACE (City and state or country) <u>Ill.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>usa</u> |
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| 13a. FATHER'S NAME <u>Clyde Brimm</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mary Queen</u> | | 14. NAME OF HUSBAND OR WIFE <u>Opal Brimm</u> | |
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| 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>357-09-8313</u> | 17. INFORMANT <u>Carl Litchfield Purice Mo</u> | |
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| 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>MULTIPLE INJURIES TO HEAD</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>ACUTE SHOCK (AUTO ACCIDENT)</u> | | |
| | DUE TO (c) <u>—</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"/> <u>2</u> |

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| 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 <u>—</u> Month <u>—</u> Day <u>—</u> Year <u>—</u> a.m. <u>—</u> p.m. <u>—</u> | | | |

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| 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.) <u>10-19-58</u> | 20f. CITY, TOWN, OR LOCATION <u>POPLAR BLUFF, MISSOURI</u> | COUNTY <u>—</u> STATE <u>—</u> |
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21. I attended the deceased from 12:40 AM to 6:20 AM and last saw her alive on 10-19-58
Death occurred at 6:20 AM on the date stated above; and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>Sam S. Davis, M.D.</u> | 22b. ADDRESS <u>POPLAR BLUFF, MISSOURI</u> | 22c. DATE SIGNED <u>12-18-58</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>oct 22 1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Butte Ash Hill</u> | 23d. LOCATION (City, town, or country) (State) <u>Butler Co Mo</u> |
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| 24. FUNERAL DIRECTOR <u>Floyd Morgan Purice Mo</u> | ADDRESS <u>—</u> | 25. DATE RECD. BY LOCAL REG. <u>12/27/58</u> | 26. REGISTRAR'S SIGNATURE <u>—</u> |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Wm. H. Morgan*

Licensed Embalmer No. *4640*

P. O. Address *Advance, 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.