

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

69-000547

STATE FILE NUMBER 12

Health, Welfare, Public Service

300  
-57

FILED JAN 21 1959 Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>	
b. CITY OR TOWN <u>Harrisonville</u> (If outside corporate limits, give TOWNSHIP only) Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Harrisonville</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>602 E Chestnut</u>		d. STREET ADDRESS (If outside, give location) <u>602 E. Chestnut</u>	
Length of stay in lb <u>7 years</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>BEASLEY</u> Last <u>BROOKS</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>14</u> Year <u>1959</u>		
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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>Aug 21-1873</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Berlin, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Harvey G Brooks</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Reagon</u>	14. NAME OF HUSBAND OR WIFE <u>Celia Brooks</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.	17. INFORMANT <u>Emma Myers</u> Address <u>209 N Orange</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>Pulmonary Edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cardiac insufficiency</u>		<u>2 yrs.</u>
	DUE TO (c) <u>Arteriosclerosis</u>		<u>10 yrs</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.)
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20c. TIME OF INJURY Hour <u>0</u> a.m. <u>0</u> p.m.	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 <u>Harrisonville</u> COUNTY <u>MO</u> STATE <u>MO</u>
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21. I attended the deceased from Death occurred at <u>9 Nov 1957</u> to <u>Jan 14, 1959</u> and last saw <sup>her</sup> him alive on <u>Jan 14, 1959</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>H. E. Frisch</u> (Degree or title) <u>Mo.</u>	22b. ADDRESS <u>Harrisonville</u>	22c. DATE SIGNED <u>Jan 16, 1959</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan 17-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Orient Cemetery</u>	23d. LOCATION (City, town, or county) <u>Harrisonville</u> (State) <u>Mo.</u>
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24. FUNERAL DIRECTOR <u>Bunnenburgis</u> ADDRESS <u>Harrisonville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-16-1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Gray Sebre</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature. All diseases in Part I must be causally related.

56

Apr 8 0 8 059

CASS COUNTY  
HEALTH DEPARTMENT

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 Frank E. Remmenbruger 3<sup>rd</sup>, Student Embalmer No. 568 working under my personal supervision.

Student Frank E. Remmenbruger 3<sup>rd</sup>  
Signature of Student Embalmer

Signed James R. Phillips

Licensed Embalmer No. 4641

P. O. Address Narrison

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.