

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002054  
STATE FILE NUMBER

FILED JAN 12 1959 Registration District No. 187 Primary Registration District No. 4302 Registrar's No. 16

300  
1-57

1. PLACE OF DEATH a. COUNTY <i>Livingston</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Livingston</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Chula</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Chula 0590</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>✓</i>		Length of stay in lb <i>Lifetime</i>	d. STREET ADDRESS (If outside, give location) <i>✓</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Rosa</i> Middle <i>Branson</i> Last <i>Branson</i>			4. DATE OF DEATH Month <i>January</i> Day <i>4</i> Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 16 1880</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		9b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	9. AGE (In years last birthday) <i>78</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (City and state or country) <i>Linn County Missouri</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Henry Mace</i>	
13a. FATHER'S NAME <i>Henry Mace</i>		13b. MOTHER'S MAIDEN NAME <i>Cynthia Ann Mace</i>	14. NAME OF HUSBAND OR WIFE <i>John Branson</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Preston Young, Chillicothe, Mo. R.R. 3</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i>
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) <i>H201</i>			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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>None</i> to <i>Jan 4-59</i> and last saw her alive on <i>Jan 4-59</i> Death occurred at <i>50% A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Joseph P. Conrad, M.D. R.3</i>		22b. ADDRESS <i>Chillicothe, Mo</i>	22c. DATE SIGNED <i>Jan 6-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>January 8 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Plainview Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Chula Mo</i>
24. FUNERAL DIRECTOR ADDRESS <i>F. J. Robertson Funeral Home - Chula</i>		25. DATE RECD. BY LOCAL REG. <i>1-6-59</i>	26. REGISTRAR'S SIGNATURE <i>Frances B. Neel</i>

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 traced. 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 *J. M. Robertson* .....

Licensed Embalmer No. *4388* .....  
P. O. Address *Laredo, 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.