Health, Welfare Public Service

36
300
1-57 1

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-006214
STATE FILE NUMBER

FILED FEB 17 1959 Registration District No. 170 Primary Registration District No. — Registrar's No. 20

1. PLACE OF DEATH
a. COUNTY Laclede
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Eldridge — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Eldridge — Length of stay in 1b 28 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Laclede
c. CITY OR TOWN Eldridge — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) Eldridge — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First WILLIAM Middle BOOTH Last BROWN
4. DATE OF DEATH Month Jan. Day 30 Year 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Mar. 21, 1881
9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (City and state or country) Laclede County Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Reuben Brown
13b. MOTHER'S MAIDEN NAME Mollie Crawford
14. NAME OF HUSBAND OR WIFE None.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None.
17. INFORMANT Mrs. Edith Blue, Address Eldridge, Mo.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral thrombosis (accident)	2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Chronic Heart Failure	1 month
DUE TO (c)	Arteriosclerosis Hypertension	years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1-[illegible] to 1-30-59 and last saw ~~her~~ him alive on 1-2-59
Death occurred at 1:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [illegible] (Degree or title)
22b. ADDRESS 158 E. [illegible]
22c. DATE SIGNED 1/31/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 2/1/59
23c. NAME OF CEMETERY OR CREMATORY Old Bolles Cemetery
23d. LOCATION (City, town, or county) (State) Laclede County Missouri

24. FUNERAL DIRECTOR S. R. Palmer ADDRESS Lebanon Mo
25. DATE RECD. BY LOCAL REG. 2-7-1959
26. REGISTRAR'S SIGNATURE Stella L. Day

(Licensed Embalmer's Statement on Reverse Side)

Date Filed FEB 16 1959

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 S. R. Palmer

Licensed Embalmer No. 2208

P. O. Address Lebanon

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.