

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008400
STATE FILE NUMBER

FILED MAR 30 1959

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 132

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>HERMAN</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR UNIVERSITY INSTITUTION <u>Hospital</u>		Length of stay in lb <u>1 DAY</u>	d. STREET ADDRESS (If outside, give location) <u>Rt. #1</u> <u>Frame Valley Nursing Home</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHRISTINE BRANDT DOLL</u>			4. DATE OF DEATH Month Day Year <u>3 23 59</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-10-1886</u>
9. AGE (In years last birthday) <u>72</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>DRAKE, MO.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13a. FATHER'S NAME <u>ERITZ BRANDT</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>
14. NAME OF HUSBAND OR WIFE <u>UNKNOWN</u>		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>NONE</u>
17. INFORMANT <u>Hospital Record</u>		Address	
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>PNEUMOPERICARDIUM</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 or 4 minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>MEDIASTINAL EMPHYSEMA</u>			<u>9047</u> <u>45</u> <u>3 or 4 minutes</u>
DUE TO (c) <u>HEMORRHAGIC TRACHEOBRONCHITIS</u>			<u>24-48 hours?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture, left hip, peritrochanteric (femur) 21 March '59</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>"Slipped" + fell in her room at Frame Valley Nursing Home, Rt. #1, Herman, Mo.</u>		
20c. TIME OF INJURY Hour Month, Day, Year <u>11</u> <u>21 March '59</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>		20f. CITY, TOWN, OR LOCATION <u>Herman, Gasconade, Mo.</u>	STATE
21. I attended the deceased from <u>21 March '59</u> to <u>23 March '59</u> and last saw her alive on <u>23 March '59</u> Death occurred at <u>1:35 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John L. Holmes, M.D.</u> (Degree or title)		22b. ADDRESS <u>Columbia, Mo.</u>	DATE SIGNED <u>23 March '59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3/23/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HERMANN CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>Herman Mo</u>
24. FUNERAL DIRECTOR <u>HUGO H. BLUMER</u> ADDRESS <u>Herman Mo</u>	25. DATE RECD. BY LOCAL REG. <u>March 23, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

Licensed Embalmer No.

P. O. Address

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.