

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014052

State File No.

FILED MAY 12 1959

BIRTH NO. _____ REG. DIST. NO. 157 PRIMARY REG. DIST. NO. 3440 Registrar's No. 122

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Chillicothe</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>0590</u> OR TOWN <u>Chillicothe</u>	
c. LENGTH OF STAY (in this place) <u>1 1/2 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>707 1/2 Locust St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Susan's Nursing Home</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>ALBERT</u>	b. (Middle) <u>RAYMOND</u>	c. (Last) <u>BROWN</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May 5 1959</u>
-------------------------------------	--------------------------	----------------------------	------------------------	---------------------------------------------------------

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 6, 1907</u>	9. AGE (In years last birthday) <u>52</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 12 HRS. Hours <u>0</u> Min. <u>0</u>
--------------------	-------------------------------	-----------------------------------------------------------------------	--------------------------------------	-------------------------------------------	-----------------------------------------------	-----------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>CB&Q RR</u>	11. BIRTHPLACE (State or foreign country) <u>0</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
-----------------------------------------------------------------------------------------------------------	------------------------------------------------------	----------------------------------------------------	--------------------------------------------

13a. FATHER'S NAME <u>Calvin Brown</u>	13b. MOTHER'S MAIDEN NAME <u>Pearl Rorbeck</u>	14. NAME OF HUSBAND OR WIFE <u>Elene Shipp</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>707-07-1774</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Elene Brown</u>	ADDRESS <u>707 1/2 Locust St. Chillicothe, Mo.</u>
--------------------------------------------------------------------------------------------------------------------	--------------------------------------------	-----------------------------------------------------------	----------------------------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs approx 12 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Aspiration pneumonia and pulmonary edema</u>	DUPLICATE	
ANTECEDENT CAUSES	MORIBUND CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>		
	DUE TO (b) <u>Multiple sclerosis</u>		
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	----------------------------------------------------------------------------------

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------------

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
-------------------------------------------------	--------------------------------------------------------------------------------------------------------	----------------------------

22. I hereby certify that I attended the deceased from Oct, 1956, to May 5, 1959, that I last saw the deceased alive on May 5, 1959, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>William L. Fair, M.D.</u> (Degree or title)	23b. ADDRESS <u>Chillicothe, Mo</u>	23c. DATE SIGNED <u>5/6/59</u>
---------------------------------------------------------------	-------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>5/12/59</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mound City Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Mound City, Missouri</u>
---------------------------------------------------------	--------------------------	-----------------------------------------------------------	---------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. <u>5-6-59</u>	REGISTRAR'S SIGNATURE <u>Frances B Neill</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>NORMAN FUNERAL HOME</u>	ADDRESS <u>Chillicothe, Mo.</u>
----------------------------------------	----------------------------------------------	-------------------------------------------------------------	---------------------------------

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAY 14 1939

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.....

Linda L. Bolin

Student Embalmer No. 573

working under my personal supervision.

Student *Linda L. Bolin*
Student Embalmer

Signed *John Bolin*

Licensed Embalmer No. 5035

P. O. Address Chillicothe, Misso

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.