

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014552

STATE FILE NUMBER

FILED APR 23 1959

Registration District No. 314 Primary Registration District No. 4489 Registrar's No. 18

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| 1. PLACE OF DEATH a. COUNTY <u>St Clair</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Hickory</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Osceola</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Wheatland Township</u> In/Outside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Osceola Hospital</u> | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) <u>Miles N. of Wheatland</u> |
| | | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Lyle</u> Middle <u>Deaton</u> Last <u>Breshears</u> | | | 4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1959</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 10 - 1914</u> | | 9. AGE (In years last birthday) <u>44</u> |
| | | | IF UNDER 1 YEAR Months <u>4</u> Days <u>25</u> | IF UNDER 24 HRS Hours <u></u> Min. <u></u> | |

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u> | 11. BIRTHPLACE (City and state or country) <u>Wheatland, Mo</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Asa Breshears</u> | 13b. MOTHER'S MAIDEN NAME <u>Bertie Campbell</u> | 14. NAME OF HUSBAND OR WIFE <u>Cleo Breshears</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>Yes World War II</u> | 16. SOCIAL SECURITY NO. <u>497-22-3008</u> | 17. INFORMANT <u>Norris Breshears - Wheatland, Mo</u> | Address |
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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>Trauma by auto accident - multiple fractures - skull, chest, left hip & forearm</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> |
| 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) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 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>auto hit tree</u> |
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| 20c. TIME OF INJURY Hour <u>3:00</u> Month <u>april</u> Day <u>5</u> Year <u>59</u> am <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> | 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>farm to market road</u> | 20f. CITY, TOWN, OR LOCATION <u>Hickory</u> | COUNTY <u>MO.</u> | STATE |
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| 21. I attended the deceased from <u>5 April 59</u> to <u>5 April 59</u> and last saw <u>him</u> alive on <u>5 April 59</u> Death occurred at <u>5:08</u> p. on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u> | 22b. ADDRESS <u>Osceola Mo.</u> | 22c. DATE SIGNED <u>5 April 59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>April 18 - 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Wesley Spring Branch Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Hickory, Mo.</u> |
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| 24. FUNERAL DIRECTOR <u>[Signature]</u> | ADDRESS <u>Wheatland, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>4-9-59</u> | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

APR 8 1954

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 *Chas Gilbert Hathaway*

Licensed Embalmer No. *4267*

P. O. Address *W. S. ...*

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.