

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020433

STATE FILE NUMBER

FILED JUL 3 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 669

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Buchanan				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Allison Rest Home 1018 N. 3rd St.		Length of stay in lb 2 years		b/d. STREET ADDRESS (If outside, give location) 1018 N. 3rd St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First SAMUEL Middle Last BRANSON				4. DATE OF DEATH Month June Day 23 Year 1959				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 13, 1873		9. AGE (In years last birthday) 86	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) Ret. Laborer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Franklin County, Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John B. Branson			13b. MOTHER'S MAIDEN NAME Lurinda Noland			14. NAME OF HUSBAND OR WIFE Verna P.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Address Albert A. Branson, Savannah, Mo			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage							INTERVAL BETWEEN ONSET AND DEATH 4 hrs.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis							Ukn.	
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"/>	
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 Month, Day, Year 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 8/18/58 to 6/23/59 and last saw ^{xxx} him alive on 6/23/59 Death occurred at 9:35 P m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) S. E. McInerney, M.D.				22b. ADDRESS 214 North 3rd St. St. Joseph, Mo DATE SIGNED 6/25/59				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 6/25/1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery			23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.		
24. FUNERAL DIRECTOR Victor Bourson ADDRESS St. Joseph, Mo.			25. DATE RECD. BY LOCAL REG. June 27, 1959			26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell		

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
 All diseases in Part I must be causally related.
 S. E. McInerney, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *William Spalding*

Licensed Embalmer No. *4535*

P. O. Address *St. Joseph, 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.