

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 22 1959

59-025921

STATE FILE NUMBER

Registration District No. 207 Primary Registration District No. _____ Registrar's No. 19

1. PLACE OF DEATH a. COUNTY <u>Maries</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Maries</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Miller Twp.</u>		Length of stay in lb <u>30 yrs</u>	c. CITY OR TOWN <u>Dixon, Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>His Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Tavern Route</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>none</u> Last <u>Brune</u>			4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1959</u>	
---	--	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/9/89</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>1</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
--------------------	-------------------------------	---	--------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Osage Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---	--	---	---

13a. FATHER'S NAME <u>Peter Brune</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Richter</u>	14. NAME OF HUSBAND OR WIFE <u>Theresa Brune</u>
---------------------------------------	--	--

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 I.</u>	16. SOCIAL SECURITY NO. <u>495-40-7628</u>	17. INFORMANT Address <u>Theresa Brune, Dixon, Mo.</u>
--	--	--

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>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</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) _____	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

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 _____ a.m. _____ p.m. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 _____ to _____ and last saw her/him alive on _____.
Death occurred at 6:15 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree) or title <u>Coroner</u>	22b. ADDRESS <u>Maries Co. Vienna, Mo.</u>	22c. DATE SIGNED <u>7/11/59</u>
--	--	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/13/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Guardian Angel</u>	23d. LOCATION (City, town, or county) (State) <u>Brinktown, Mo.</u>
---	--------------------------	--	---

24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>Vienna, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7-12-59</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
--	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 28 1951

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by me, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed McBumigden

Licensed Embalmer No. 3664

P. O. Address Sienna

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.