

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029647

FILED VS SEP 1 1959

Registration District No. 171 Primary Registration District No. 5639 Registrar's No. 422

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Lafayette</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Washington Township</b>		Length of stay in lb <b>58 yrs</b>		c. CITY OR TOWN <b>Mayview</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>I Mi. West of Mayview</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>I Mile West Of Mayview</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Virginia</b> Last <b>Brown</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>25</b> Year <b>1959</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3/15/1901</b>		9. AGE (last birthday) <b>58</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Lafayette Co., Mo.</b>				11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY			
13a. FATHER'S NAME <b>James Kincheloe</b>				13b. MOTHER'S MAIDEN NAME <b>Nannie Turley</b>				14. NAME OF HUSBAND OR WIFE <b>Robert L. Brown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>				16. SOCIAL SECURITY NO. <b>500-22-5982</b>		17. INFORMANT <b>Robert L. Brown</b> Address <b>Mayview, Mo.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Liver Failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Metastatic Carcinoma of the breast</b> DUE TO (c) <b>right</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 mo. 6 years.</b>			
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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>Aug 5, 1959</b> to <b>Aug 25, 1959</b> and last saw <b>her</b> alive on <b>Aug 25, 1959</b> Death occurred at <b>11:05 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>H.E. Fulberson M.D.</b>				22b. ADDRESS <b>Higginsville Mo</b>				22c. DATE SIGNED <b>8-27-59</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8/27/1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Odessa Cemetery</b>		23d. LOCATION (City, town, or county) <b>Odessa</b>		STATE <b>Mo.</b>					
24. FUNERAL DIRECTOR <b>Husman - Sparks</b> ADDRESS <b>Odessa, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>8/27/1959</b>		26. REGISTRAR'S SIGNATURE <b>Emma Davidson</b>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John L. Keenan

Licensed Embalmer No. 7541

P. O. Address Albany, N.Y.

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.