

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 24 1959

59-029777

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 239

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Marion</u>				
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Length of stay in 1b <u>Life</u>		c. CITY OR TOWN <u>Hannibal</u>		(Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>314a N.7th.St.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>314a N.7th.St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Isabelle</u> Middle <u>Brinkman</u> Last <u>Brinkman</u>				4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 25, 1881</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None Sitter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None Children</u>		11. BIRTHPLACE (City and state or country) <u>Hannibal, Missouri</u>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>Joseph Brinkman</u>			13b. MOTHER'S MAIDEN NAME <u>Rachel Cohn</u>			14. NAME OF HUSBAND OR WIFE		
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>492-40-6266</u>		17. INFORMANT Address <u>Mrs. Milton Lederer, 7385 Pershing St. St. Louis, 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 Thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</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) <u>Found dead in hall of her home about 11:00 A.M. 8-13-59</u>							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 checked="" 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 <u>7-20-59</u> to <u>8-13-59</u> and last saw her alive on <u>8-7-59</u> Death occurred at <u>during A.M. 8-13-59</u> 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>M. D.</u>				22b. ADDRESS <u>100 N. Sixth, Hannibal, Mo.</u>		22c. DATE SIGNED <u>8-14-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-16-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jewish Cemetery</u>		23d. LOCATION (City, town, or county) <u>Hannibal, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Jack Schwartz, Hannibal, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>8-15-59</u>		26. REGISTRAR'S SIGNATURE <u>Dr. E.M. Luede by W.C. Fisher</u>		

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

Jack Schwartz

Licensed Embalmer No. 4400

P. O. Address Hannibal

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.