

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 17 1959

59-029892

STATE FILE NUMBER

Registration District No. 231 Primary Registration District No. 231 Registrar's No. 194

1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Nodaway</u>	
b. CITY (if outside corporate limits give TOWNSHIP only) OR TOWN <u>Maryville</u>		c. CITY OR TOWN <u>Maryville</u>	
Length of stay in lb <u>four</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>609 N Fillmore</u>		d. STREET ADDRESS (If outside, give location) <u>609 N Fillmore</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Mary</u> Last <u>Bracken</u>			4. DATE OF DEATH Month <u>7</u> Day <u>26</u> Year <u>1959</u>			
SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/12/1880</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR IF UNDER 2 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home-own</u>		11. BIRTHPLACE (City and state or country) <u>Wray Colo-</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>

13a. FATHER'S NAME <u>Walter D. Bracken</u>		13b. MOTHER'S MAIDEN NAME <u>Cornelia Wood</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown.</u>		17. INFORMANT <u>James Bracken-Snoqualmie Wash-</u>	
Address					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
IMMEDIATE CAUSE (a) <u>Fractured Skull</u>			
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 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>Fell down basement stairs at her home</u>	
20c. TIME OF INJURY Hour <u>8:00</u> P.M. Month, Day, Year <u>7 26 59</u>		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.) <u>Home</u>	
		20f. CITY, TOWN, OR LOCATION <u>Maryville</u>		COUNTY <u>Nodaway</u> STATE <u>Mo.</u>	

21. I attended the deceased from _____ to _____ and last saw her alive on _____
 Death occurred Sometime Sunday AM 7-26-59 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W.R. Jackson, M.D.</u>		22b. ADDRESS <u>Maryville, Mo</u>		22c. DATE SIGNED <u>8/13/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7/31/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cem - Quitman Mo</u>	
23d. LOCATION (City, town, or county) <u>Maryville Mo</u>		23e. STATE <u>Mo</u>			

24. FUNERAL DIRECTOR <u>W. C. Johnson</u>		ADDRESS <u>Maryville Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8-18-59</u>		26. REGISTRAR'S SIGNATURE <u>Bess Bolt</u>	
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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 

Licensed Embalmer No. 3374

P. O. Address Maryville

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.