

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038897

FILED VS DEC 8 1959 38

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 584

STATE FILE NUMBER

UNDECEASED

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>3 days</u>		c. CITY OR TOWN <u>Columbia</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>Boone County Hospital</u>				Insider Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Route #6</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Kaye Brown</u>				4. DATE OF DEATH Month Day Year <u>November 27, 1959</u>				
5. SEX <u>Male</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>11-24-59</u>	9. AGE (last birthday)		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Columbia, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Robert Allen Brown</u>			13b. MOTHER'S MAIDEN NAME <u>Dorothy Rebecca Gilpin</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)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Dorothy Brown, Columbia, 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>CONGENITAL HEART DISEASE - TWO CHAMBERED HEART WITH HYPOPLASIA OF THE LEFT AURICLE, LEFT VENTRICLE</u> DUE TO (b) <u>AND THE AORTA.</u> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>3da</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Maternal Diabetes Mellitus</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 checked="" type="checkbox"/> NO <input 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. 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 <u>11/24/59</u> to <u>11/27/59</u> and last saw ^{her} him alive on <u>11/26/59</u> Death occurred at <u>11/27/59</u> <u>3:15 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Deputy or title) <u>Edward J. Washington M.D.</u>				22b. ADDRESS <u>Columbia, Mo</u>			22c. DATE SIGNED <u>11/29/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		
<u>Burial</u>		<u>Nov. 28, 1959</u>		<u>Memorial Park Cem.</u>		<u>Columbia, Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Lyman Sprinkle Columbia, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Nov 28 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</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 George B. I. Hamm

Licensed Embalmer No. 4425

P. O. Address Columbia

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.