

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 43704

FILED VS JAN - 4 1960 77

Registration District No. \_\_\_\_\_ Primary Registration District No. 3016 Registrar's No. 365

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>COLE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>OSAGE</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JEFFERSON CITY</b>		Length of stay in 1b <b>13 days</b>		c. CITY OR TOWN <b>CRAWFORD</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>CHARLES STILL HOSPITAL</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>_____</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>CHRISTINE</b> Last <b>BRANDT</b>				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>26</b> , Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6/11/1874</b>	9. AGE (last birthday) <b>82</b>	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) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (City and state or country) <b>Richfountain, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>William Luecke</b>			13b. MOTHER'S MAIDEN NAME <b>Christine Bode</b>		14. NAME OF HUSBAND OR WIFE <b>Ben J. Brandt</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>None</b>	17. INFORMANT Address <b>Mrs. Al. Krieg, Linn, Mo. R # 2</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>Circulatory Failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Hypostatic pneumonia</b> DUE TO (c) <b>Cor pulmonale chronic</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <b>Bronchiectasis, Chronic</b>						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 _____ 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 <b>12-1-59</b> , to <b>12-26-59</b> and last saw her alive on <b>12-26-59</b> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>William W. Baldwin DO</b>				22b. ADDRESS <b>Linn</b>			22c. DATE SIGNED <b>12/26/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 29, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. George's</b>		23d. LOCATION (City, town, or county) <b>Linn, Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Clyde Morton</b>		ADDRESS <b>Linn, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>28 December 1959</b>	26. REGISTRAR'S SIGNATURE <b>R. H. ...</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 James M. Mott

Licensed Embalmer No. 4125

P. O. Address Lincoln

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.