

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 4 0 2 9

FILED VS DEC 28 1959

STATE FILE NUMBER

Registration District No. 138 Primary Registration District No. 4220 Registrar's No. 40

ENDED

1. PLACE OF DEATH a. COUNTY <u>Hickory</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Hickory</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wheatland</u>		Length of stay in 1b		c. CITY OR TOWN <u>Wheatland</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>Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Jane</u> Last <u>Sherman</u>				4. DATE OF DEATH Month <u>Dec</u> ; Day <u>14</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 type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/1/1869</u>	9. AGE (last birthday) <u>90</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (City and state or country) <u>Hickory County Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Robert H. Brownlee</u>			13b. MOTHER'S MAIDEN NAME <u>Jane A. Goodrich</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>			
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>None</u>	17. INFORMANT Address <u>Eva Cooper, Weaubleau Missouri</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>Brandial Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>apoplexy of Basilar</u>						<u>20 days</u>		
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 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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>  </u> <u>  </u> <u>  </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.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE	
21. I attended the deceased from <u>1947</u> to <u>12-15-59</u> and last saw her <u>  </u> him <u>  </u> alive on <u>  </u>				Death occurred at <u>8:10 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>J. E. Bruggs D.O.</u>			(Degree or title)	22b. ADDRESS <u>Wheatland Missouri</u>		22c. DATE SIGNED <u>12/15/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/16/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		23d. LOCATION (City, town, or county) <u>Quincy Missouri</u>		(State)		
24. FUNERAL DIRECTOR <u>Godrich Funeral Home, Osceola Mo</u>			ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Dec 16. 1959</u>	26. REGISTRAR'S SIGNATURE <u>May Johnson</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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**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 Paul Quintana

Licensed Embalmer No. 3990

P. O. Address Osceola,

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.

no other person shall sign