

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS

JAN - 7 1960

277

Primary Registration District No. 4411

Registrar's No. 59

'59 045011

STATE FILE NUMBER

MAILED

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>PIKE</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BOWLING GREEN</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>PIKE</u> c. CITY OR TOWN <u>BOWLING GREEN</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>LOCUST STREET</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES ELMER BROWN</u>			4. DATE OF DEATH Month Day Year <u>DECEMBER 26 1959</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</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>12-29-94</u>	9. AGE (last birthday) <u>64</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>RAILROAD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOWLING GREEN Mo</u>		11. BIRTHPLACE (City and state or country) <u>BOWLING GREEN Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>JAMES W. BROWN</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH ANN DOUGLAS</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>709-12-1164</u>		17. INFORMANT Address <u>IMOGENE JOHNSON, BOWLING GREEN, 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>PULMONARY HEMORRHAGE</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) <u>RT. LUNG CANCER + POSSIBLE T.B.</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) <u>NONE EXCEPT PNEUMONIA</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 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>8/29/59</u> to <u>12/26/59</u> and last saw him alive on <u>12/26/59</u> Death occurred at <u>1150 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Ralph H. Hayden D.O.</u>			22b. ADDRESS <u>519 W. MAIN BOWLING GREEN Mo.</u>		22c. DATE SIGNED <u>12/29/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>12-30-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BOWLING GREEN CEMETERY, BOWLING GREEN, Mo.</u>		23d. LOCATION (City, town, or county) (State) <u>Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>TRACE BANKHEAD, BOWLING GREEN, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1-2-60</u>		26. REGISTRAR'S SIGNATURE <u>Bill Robinson</u>			

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 15 1960

FEB 4 1960

JAN 26 1960

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

Karol Kisk

Licensed Embalmer No.

4597

P. O. Address

Bawling

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.