

# IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 28 1960

Registration District No. 179 Primary Registration District No. 4287 Registrar's No. 44 STATE FILE NUMBER 60-011685

1. PLACE OF DEATH a. COUNTY <b>Lincoln</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Lincoln</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Troy</b>		Length of stay in 1b <b>1 Month</b>	c. CITY OR TOWN <b>Moscow Mills</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>600 Cap Au Gris</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Elizabeth</b> Last <b>Braungardt</b>			4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>1960</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>6/9/72</b>	9. AGE (last birthday) <b>87</b>	IF UNDER 1 YEAR Months Days 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>Lincoln Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Rudolph August Stork</b>		13b. MOTHER'S MAIDEN NAME <b>Katherine W. Althoff</b>		14. NAME OF HUSBAND OR WIFE <b>George Braungardt</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>Julius Braungardt, Moscow Mills, Mo.</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>Cerebral Vascular Accident</b>					INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerosis</b>						
DUE TO (c) <b>Dementia</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (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 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>10/12/59</b> to <b>3/18/60</b> and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>Charles E. Leesch M.D.</b> (Degree or title)			22b. ADDRESS <b>Troy Mo</b>		22c. DATE SIGNED <b>3/19/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3/21/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Anderson Hill Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Lincoln Co., Missouri</b>		
24. FUNERAL DIRECTOR <b>Kemper Marsh Funeral Home, Troy, Mo.</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>3-22-1960</b>	26. REGISTRAR'S SIGNATURE <b>Charlotte Leek</b>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NDED

**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 Joseph J. Mason

Licensed Embalmer No. 3932

P. O. Address Troy, Missouri

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.