

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024741

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 754 STATE FILE NUMBER

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

1. PLACE OF DEATH
a. COUNTY **GREENE**

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE **MO.** b. COUNTY **GREENE**

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **SPRINGFIELD** Length of stay in 1b

c. CITY OR TOWN **SPRINGFIELD** Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **MERCY HOSPITAL** Inside Limits Yes No d. STREET ADDRESS (If outside, give location) **2458 N. RAMSEY** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year
CHARLES BREAZEALE **AUG. 7, 1961**

5. SEX **MALE** 6. COLOR OR RACE **WHITE** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **26 JAN. 1880** 9. AGE (last birthday) **81** IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **FARMER** 10b. KIND OF BUSINESS OR INDUSTRY **RETIRED** 11. BIRTHPLACE (City and state or country) **MISSOURI** 12. CITIZEN OF WHAT COUNTRY **USA**

13a. FATHER'S NAME **WILLIAM BREAZEALE** 13b. MOTHER'S MAIDEN NAME **CLARA FIELDEN** 14. NAME OF HUSBAND OR WIFE **DECEASED**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **NO** 16. SOCIAL SECURITY NO. **UNKNOWN** 17. INFORMANT Address **NINA POOL (DAUGHTER) MT. GROVE, MO.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **GENERALIZED ARTERIOSCLEROSIS** INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **URINARY TRACT INFECTION + UREMIA** PART III. If deceased was female was there a pregnancy in last 90 days. Yes N. Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 **1956** to **8-7-61** and last saw ^{her}him alive on **8-7-61**
Death occurred at **1:55** P.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Dean Currier Gham, M.D.** 22b. ADDRESS **1715 BOONVILLE SPRINGFIELD, MO.** 22c. DATE SIGNED **8-7-61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 23b. DATE **8-9-61** 23c. NAME OF CEMETERY OR CREMATORY **PATTERSON CEM.** 23d. LOCATION (City, town, or county) (State) **GREENE COUNTY, MO.**

24. FUNERAL DIRECTOR ADDRESS **KRINGNERS** **SPGFD. MO.** 25. DATE RECD. BY LOCAL REG. **8-10-61** 26. REGISTRAR'S SIGNATURE **Effie G. Melton**

JC

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Glen D Williams

Licensed Embalmer No. 4651

P. O. Address Springfield

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.