

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-034478
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 132

Primary Registration District No. 5

Registrar's No. 178

FILED OCT 1 1962

VS 300
Rev. 4/59

10400
20400

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|---------------------------------|--|--|
| 1. PLACE OF DEATH | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | | | | | | |
| a. COUNTY <u>GRUNDY</u> | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Franklin twp</u> | | Length of stay in lb | | a. STATE <u>MO</u> b. COUNTY <u>GRUNDY</u> | | c. CITY OR TOWN <u>SPICKARD</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOME FRANKLIN TOWNSHIP</u> | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>FRANKLIN TOWNSHIP</u> | | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | | | | | 4. DATE OF DEATH | | | | | |
| First | | Middle | | Last | | Month | | Day | | Year | |
| <u>GUY</u> | | <u>CLIFFORD</u> | | <u>BREWER</u> | | <u>SEPT</u> | | <u>22</u> | | <u>1962</u> | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>JULY-28-1891</u> | | 9. AGE (last birthday) <u>71-1-24</u> | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or county) <u>SPICKARD MO</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | | |
| 13a. FATHER'S NAME <u>WILLIAM H. BREWER</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>CORA M. CORNWELL</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>NORA BREWER</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. | | 17. INFORMANT Address <u>CHARLES BREWER Spickard MO</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> | | | | | | | | | | <u>few min</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio sclerosis</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 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 | | 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>April 17-1962</u> to <u>Sept 22-1962</u> and last saw ^{her} him alive on <u>9-12-62</u> Death occurred at <u>7:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>L. H. Mullers M.D.</u> | | | | | | 22b. ADDRESS <u>Trenton Mo</u> | | | 22c. DATE SIGNED <u>9-24-62</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | 23b. DATE <u>SEPT-24-1962</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>MASONIC CEMETERY</u> | | | 23d. LOCATION (City, town, or county) <u>SPICKARD</u> | | (State) <u>MO.</u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>WISE FUNERAL HOME Spickard MO.</u> | | | | | | 25. DATE RECD. BY LOCAL REG. <u>9-25-62</u> | | 26. REGISTRAR'S SIGNATURE <u>Frederick</u> | | | |

USE BLACK INK OR TYPEWRITER RIBBON

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 *Cross Wise*

Licensed Embalmer No. 3771

P. O. Address *Spickard Mo.*

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.