

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-031342

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1012

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 26 1963	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>	Length of stay in 1b <u>60 years</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>621 E. Colorado Ave.</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. STREET ADDRESS (If outside, give location) <u>621 E. Colorado Ave.</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First <u>Bessie</u> Middle <u>May</u> Last <u>Brazzell</u>	
4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1963</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>Aug. 28, 1879</u>
9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during past working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Our home</u>
11. BIRTHPLACE (City and state or country) <u>Eagleville, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Henry Tripp</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Allen</u>
14. NAME OF HUSBAND OR WIFE <u>George Brazzell</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>	17. INFORMANT Address <u>Mrs. Alice Ellis 621 E. Colorado Ave.</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>CARDIO-RENAL-VASCULAR COLLAPSE</u> DUE TO (b) <u>VIRAL INFLUENZA</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u> <u>5 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>FRACTURED NECK OF LEFT FEMUR MARCH 3, 1963, - BED RIDDEN SINCE</u>	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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>MARCH 3, 1962</u> to <u>AUGUST 20, 1963</u> and last saw her <u>alive</u> on <u>AUGUST 20, 1963</u> Death occurred at <u>11:30 a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>E. J. Gross MD</u> (Degree or title)	22b. ADDRESS <u>5105 KING HILL AVE. ST. JOSEPH, MO. 64504</u>
22c. DATE SIGNED <u>AUG. 21, 1963</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug. 22, 1963</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Joseph, Mo.</u> (State)
24. FUNERAL DIRECTOR <u>Clark Funeral Home</u> ADDRESS <u>St. Joseph, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Aug 21, 1963</u>
26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF E. J. Gross, M.D. MEDICAL CERTIFICATION

VS 300 Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

Dr. Gross

Permit issued 8.21.63

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STATEMENT BY LICENSED EMBALMER

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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 Alvin E. Bayan

Licensed Embalmer No. 4795

P. O. Address St. Joseph MD

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.