

TYPE/PRINT IN PERMANENT BLACK INK, FOR INSTRUCTIONS SEE OTHER SIDE AND HANDBOOK.

MISSOURI DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 Delayed 235000

STATE FILE NUMBER
124 - 33-042449

REGISTRATION DISTRICT NO. **067**

REGISTRAR'S NUMBER

DECEDENT

affidavit signed by Myrtle Judy on 3/19/99 A picture of the decedent is attached to this certificate.

1. DECEDENT'S NAME (First, Middle, Last) **DCNA MAE BROWN** 2. SEX **Female** 3. DATE OF DEATH (Month, Day, Year) **June 30, 1933**

4. SOCIAL SECURITY NO. 5a. AGE - Last Birthday (Years) **30** 5b. UNDER 1 YEAR MONTHS 5c. UNDER 1 DAY HOURS MINUTES 6. DATE OF BIRTH (Month, Day, Year) **Aug. 18, 1903** 7. BIRTHPLACE (City and State or Foreign Country) **Douglas**

8. WAS DECEDENT EVER IN U.S. ARMED FORCES? Yes No Unk. 8a. PLACE OF DEATH (Check only one; see instructions on other side)
 HOSPITAL: Inpatient ER/Outpatient DOA OTHER: Nursing Home Residence Other (Specify)

9b. FACILITY NAME (If not institution, give street and number) 9c. CITY, TOWN, OR LOCATION OF DEATH **Drury** 9d. COUNTY OF DEATH **Douglas**

10. MARITAL STATUS - Married, Never Married, Widowed, Divorced, (Specify) **Married** 11. SURVIVING SPOUSE'S NAME (If wife, give full maiden name) **Willie Brown** 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) **Housewife** 12b. KIND OF BUSINESS OR INDUSTRY

13a. RESIDENCE - STATE **Missouri** 13b. COUNTY **Douglas** 13c. CITY, TOWN, OR LOCATION **Drury** 13d. ZIP CODE

13e. STREET AND NUMBER 13f. INSIDE CITY LIMITS Yes No 13g. YEARS AT PRESENT ADDRESS Under 5 5-9 10-19 20 or more

14. WAS DECEDENT OF HISPANIC ORIGIN (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) No Yes Specify: 15. RACE - American Indian, Black, White, etc. (Specify) **White** 16. DECEDENT'S EDUCATION (Specify only highest grade completed)
 Elementary/Secondary (0-12) **8th** College (1-4 or 5+)

PARENTS

17. FATHER'S NAME (First, Middle, Last) **William David Scott** 18. MOTHER'S NAME (First, Middle, Maiden Surname) **Rosa Etta Medlock**

INFORMANT

19a. INFORMANT'S NAME (Type/Print) **Judy Jeffery** 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **6200 S. Hillcrest Dr., Okla. City, Ok. 73159**

DISPOSITION

20a. BURIAL, CREMATION, OTHER (Specify) **Burial** 20b. DATE OF DISPOSITION (Month, Day, Year) **7-2-1933** 20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) **Yates** 20d. LOCATION - City or Town, State **Drury, Mo.**

CAUSE OF DEATH

notarized by Myrtle Judy and a copy of death certificate is attached to this certificate.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH *Myrtle Judy* 22a. NAME AND ADDRESS OF FACILITY **NA** 22b. FUNERAL ESTABLISHMENT LICENSE NUMBER **NA**

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
 IMMEDIATE CAUSE (Final disease or condition resulting in death) **Child Birth**
 DUE TO (OR AS A CONSEQUENCE OF):
 SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. ENTER UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST

CAUSE OF DEATH

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? Yes No Unk. 25a. WAS AN AUTOPSY PERFORMED? Yes No 25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Yes No

Verified by a Myrtle Judy the grave monument clipping. Date of death 6/30/33

26. MANNER OF DEATH Natural Pending Investigation Accident Suicide Could not be Determined Homicide

27a. DATE OF INJURY (Month, Day, Year) 27b. TIME OF INJURY **M** 27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent.) Yes No Unk. 27d. INJURY AT WORK? Yes No Unk. 27e. DESCRIBE HOW INJURY OCCURRED

27f. PLACE OF INJURY - At home, farm street, factory, office building, etc. (specify) 27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)

CERTIFIER

28a. (Specify) CERTIFYING PHYSICIAN MEDICAL EXAMINER/CORONER (Signature and Title) **Unknown** 28b. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. 28c. DATE SIGNED (Month, Day, Year) 28d. TIME OF DEATH

29a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print) 29b. MO. LICENSE NUMBER 30. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? Yes No

31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) 32. REGISTRAR'S SIGNATURE *Harland H. Land* 33. DATE RECEIVED BY LOCAL REGISTRAR (Month, Day, Year) **March 19, 1999**

DO NOT WRITE ON THIS STUB

7-cy	12a	23u	27g-co
9a	13e	23-sc1	29g-cy
9b	13b	27-sc2	29a
9c	14	27e-f	29b
12b	15	27g-st	

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 _____ Signed _____
Signature of Student Embalmer

Licensed Embalmer No. _____

NAME OF DECEDENT _____ P.O. Address _____

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.

INSTRUCTIONS FOR SELECTED ITEMS

Item 9a - Place of Death

If the death was pronounced in a hospital, check the box indicating the decedent's status at the institution (inpatient, emergency room/outpatient, or dead on arrival (DOA). If death was pronounced elsewhere, check the box indicating whether pronouncement occurred at a nursing home, residence, or other location. If other is checked, specify where death was legally pronounced, such as a physician's office, the place where the accident occurred, or at work.

Item 13a-g - Residence of Decedent

Residence of the decedent is the place where he or she actually resided. This is not necessarily the same as "home state," or "legal residence." Never enter a temporary residence such as one used during a visit, business trip, or a vacation. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and should be considered as the place of residence. If a decedent had been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, report the location of that facility in items 13a through 13g. If the decedent was an infant who never resided at home, the place of residence is that of the parent(s) or legal guardian. Do not use an acute care hospital's location as the place of residence for any infant.

Item 23 - Cause of Death

The cause of death means the disease, abnormality, injury or poisoning that caused the death, not the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. In Part I the immediate cause of death is reported on line (a). Antecedent conditions, if any, which gave rise to the cause are reported on lines (b), (c), and (d). The underlying cause should be reported on the last line used in Part I. No entry is necessary on lines (b), (c), and (d) if the immediate cause of death on line (a) describes completely the chain of events. ONLY ONE CAUSE SHOULD BE ENTERED ON A LINE. Additional lines may be added if necessary. Provide the best estimate of the interval between the onset of each condition and death. Do not leave the interval blank; if unknown, so specify. In Part II, enter other important diseases or conditions that may have contributed to death but did not result in the underlying cause of death given in Part I.

EXAMPLE OF PHYSICIAN CERTIFICATION:	23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
	IMMEDIATE CAUSE → <small>(Final disease or condition resulting in death)</small>	a. <u>Rupture of myocardium</u> DUE TO (OR AS A CONSEQUENCE OF):	Mins
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	b. <u>Acute myocardial infarction</u> DUE TO (OR AS A CONSEQUENCE OF):	6 days
		c. <u>Chronic ischemic heart disease</u> DUE TO (OR AS A CONSEQUENCE OF):	5 years
CAUSE OF DEATH	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes, Chronic obstructive pulmonary disease, smoking</u>		
	24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	25a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	25 b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) M. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK.
	27d. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK.	27e. DESCRIBE HOW INJURY OCCURRED	
	27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)	27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

EXAMPLE OF MEDICAL EXAMINER OR CORONER	23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
	IMMEDIATE CAUSE → <small>(Final disease or condition resulting in death)</small>	a. <u>Cerebral laceration</u> DUE TO (OR AS A CONSEQUENCE OF):	10 mins.
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	b. <u>Open skull fracture</u> DUE TO (OR AS A CONSEQUENCE OF):	10 mins.
		c. <u>Automobile accident</u> DUE TO (OR AS A CONSEQUENCE OF):	10 mins.
CAUSE OF DEATH	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		
	24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.	25a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	25 b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
26. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	27a. DATE OF INJURY (Month, Day, Year) 11/15/85	27b. TIME OF INJURY 1 p.M.	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK.
	27d. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> UNK.	27e. DESCRIBE HOW INJURY OCCURRED 2-car collision-driver	
	27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) Street	27g. LOCATION (Street and Number or Rural Route Number, City or Town, State) Route 4, Jefferson City, Missouri	