

FILED JAN 27 1945
128
Registration District No.

Primary Registration District No. 5466

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town RURAL; S. CAMPBELL TWP
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
OZARK OSTEOPATHIC HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 DAY
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Wright, 114
(c) City or town Mansfield, 0
(If outside city or town limits, write "RURAL")
(d) Street No. OZARK OSTEOPATHIC HOSPITAL
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME L. P. WIS N. BRAND

3. (b) If veteran, name-war WORLD WAR I 3. (c) Social Security No. 496-0-7483

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife. IDA BRAND 6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased. AUG. 17, 1887
(Month) (Day) (Year)

8. AGE: Years 59 Months 4 Days 17 If less than one day hr. min.

9. Birthplace CARROLTON MO (City, town, or county) (State or foreign country)

10. Usual occupation PHARMACIST

11. Industry or business DRUGSTORE

12. Name OLIVER BRAND

13. Birthplace CARROLTON MO (City, town, or county) (State or foreign country)

14. Maiden name CARRIE LEWIS

15. Birthplace CARROLTON MO (City, town, or county) (State or foreign country)

16. (a) Informant IDA BRAND (b) Address WEST PLAINS, MO.

17. (a) Burial (b) Date thereof JAN 16-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Grove, Mo.

18. (a) Signature of funeral director J. D. Sliffe

(b) Address MANSFIELD MO.

19. (a) 1-16-45 (b) R. M. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 14 year 1945 hour 4:45 minute A.M.

21. I hereby certify that I attended the deceased from 1-12 1945 to 1-14 1945
that I last saw him alive on 1-14 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocardial failure

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury 2

23. Signature Richard L. Michael, M.D. (other)

Address Springfield, Mo. Date signed 1-14-45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

900

MOTHER FATHER

PHYSICIAN Underline the cause to which death should be charged statistically.

MAR 31 1952

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed: W. A. Steff
Licensed Embalmer No. 3221
P. O. Address Manfield 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 this body is not embalmed, fact should be so stated above.

X