

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **11685**

No. 300
10-48
FILED MAY 12 1949

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

BIRTH NO. _____		REG. DIST. NO. <u>47</u>		PRIMARY REG. DIST. NO. <u>3008</u>		Registrar's No. <u>152</u>			
1. PLACE OF DEATH a. COUNTY <u>Callaway.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Callaway</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton.</u>		c. LENGTH OF STAY (in this place) <u>4 months</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Wellsville.</u>		70 2			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital No. 12</u>				d. STREET ADDRESS (If rural, give location) <u>_____</u> 0 1					
3. NAME OF DECEASED (Type or Print) a. (First) <u>TOM.</u> b. (Middle) <u>_____</u> c. (Last) <u>BRAUSTETTER.</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>5 3 1949</u>						
5. SEX <u>M.O.</u>	6. COLOR OR RACE <u>N.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>D.K.</u>		9. AGE (In years) <u>72</u>	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Days	IF UNDER 4 HRS. Hours	IF UNDER 15 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mo.</u> <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>John Braustetter</u>			13b. MOTHER'S MAIDEN NAME <u>Melinda Rivere</u>			14. NAME OF HUSBAND OR WIFE <u>D.K.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) <u>D.K.</u>		16. SOCIAL SECURITY NO. <u>D.K.</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Hospital Records, Fulton Mo.</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis</u>					
				DUE TO (c) _____					
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<u>H201</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>5-2-49, 19</u> , to <u>5-3-49, 19</u> , that I last saw the deceased alive on <u>5-3-49, 19</u> , and that death occurred at <u>1:50 P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>R.P. Price M.D. by A. F. Fungo M.D.</u>				23b. ADDRESS <u>Fulton Mo.</u>			23c. DATE SIGNED <u>5-7-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>5/3/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Wellsville</u>		24d. LOCATION (City, town, or county) (State) <u>Wellsville, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>May 6-1949</u>		REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>T.B. Kells Wellsville, Mo.</u>				

RECEIVED
District Health Officer No. 9
District File Number
Date Filed MAY 11 1949

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 _____
Student Embalmer

Signed SB Stelbo

Licensed Embalmer No. 1588

P. O. Address Nelbville m

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.