

FILED APR 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12293

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>1293</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>				c. CITY (If outside corporate limits, write RURAL and give township) <u>Columbia</u>			
c. LENGTH OF STAY (In this place) <u>1 year</u>				d. STREET ADDRESS (If rural, give location) <u>811 Stewart Rd</u>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Robinson Clinic</u>				e. (First) <u>Margaret</u> b. (Middle) <u>Bragg</u> c. (Last) <u>Bragg</u>			
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>4/30/1907</u>		9. AGE (In years last birthday) <u>41</u>		10. UNDER 1 YEAR (Months) <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>NAT S. GIVENS</u>		13b. MOTHER'S MAIDEN NAME <u>MARTHA HOLLINSWORTH</u>		14. NAME OF HUSBAND OR WIFE <u>H. J. BRAGG</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Dr. H. J. BRAGG</u> ADDRESS <u>Columbia 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Massive Pulmonary Embolus</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Fatty degeneration and</u> DUE TO (c) <u>enlargement of the liver</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>5810</u>				INTERVAL BETWEEN ONSET AND DEATH	
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) m.		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>March 19, 1949</u> , to <u>March 19, 1949</u> , that I last saw the deceased alive on <u>March 19, 1949</u> , and that death occurred at <u>7 P.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Louise B. Lowry, M.D.</u> (Degree or title)				23b. ADDRESS <u>Robinson Clinic</u> <u>2625 West Paseo</u>		23c. DATE SIGNED <u>3-20-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>3/20/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>		24d. LOCATION (City, town, or county) (State) <u>Columbia Mo</u>	
DATE REC'D BY LOCAL REG. <u>3-22-49</u>		REGISTRAR'S SIGNATURE <u>Pauline Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Stine-McClure</u>		ADDRESS <u>14. C. Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Signed _____

May E. Meyer

Signed _____
Student Embalmer

Licensed Embalmer No. *14553*

P. O. Address *Kansas City, 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.