

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **22301**

FILED JUL 12 1949

BIRTH NO. _____		REG. DIST. NO. <b>341</b>		PRIMARY REG. DIST. NO. <b>6162</b>		Registrar's No. <b>27</b>	
1. PLACE OF DEATH a. COUNTY <b>Stone</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Stone</b>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>Reeds Spring Mo</b>		c. LENGTH OF STAY (In this place) <b>mo</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Reeds Spring Mo</b>		d. STREET ADDRESS (If rural, give location) <b>0</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1</b>				d. STREET ADDRESS (If rural, give location) <b>0</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>MARY</b>		b. (Middle) <b>ANN</b>		c. (Last) <b>BRANSTETTER</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>JUNE 22 1949</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>MAY 24 1858</b>	
9. AGE (In years last birthday) <b>91</b>		10. UNDER 1 YEAR Months <b>89</b>		11. BIRTHPLACE (State or foreign country) <b>MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Woodson</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Rac Branstetter Neeshw Mr.</b>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypertension Prim</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Fracturing Hip</b> DUE TO (c) <b>992</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>992</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 Days</b> <b>6 mos</b> <b>59040</b> <b>21</b>	
19a. DATE OF OPERATION <b>✓</b>		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.) <b>Home</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Reeds Newton Mo</b>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Jun 3 1949 m.</b>	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Fall</b>		21g. HOW DID INJURY OCCUR? <b>73</b>		22. I hereby certify that I attended the deceased from <b>May 19, 1949, to Jun 21, 1949</b> , that I last saw the deceased alive on <b>May 24 1949</b> , and that death occurred at <b>3:22 p.m.</b> from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <b>W. P. Leavelle M.D.</b>		23b. ADDRESS <b>Reeds Spring Mo</b>		23c. DATE SIGNED <b>6-23-49</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	
24b. DATE <b>6/24/49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Masonic</b>		24d. LOCATION (City, town, or county) (State) <b>Crane Mo</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Manlove - Moss Reeds Spring Mo</b>	
DATE REC'D BY LOCAL REG. <b>June 30-49</b>		REGISTRAR'S SIGNATURE <b>Lena Murray - Depl.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Manlove - Moss Reeds Spring Mo</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Manlove - Moss Reeds Spring Mo</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 6,

District File Number 749-807

Date Filed 7-11-49

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 \_\_\_\_\_  
Student Embalmer

Signed Henry H. Mawlor

Licensed Embalmer No. 3827

P. O. Address Camden, 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.