

FILED AUG 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24452

BIRTH NO.		REG. DIST. NO. 301		PRIMARY REG. DIST. NO. 6031		Registrar's No. 47	
1. PLACE OF DEATH a. COUNTY RIPLEY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Ripley			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL		c. LENGTH OF STAY (In this place) 15 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL (CURRENT RIVER)			
d. FULL NAME OF HOSPITAL OR INSTITUTION: DONIPHAN RT #3				d. STREET ADDRESS (If rural, give location) DONIPHAN RT #3			
3. NAME OF DECEASED (Type or Print) a. (First) hucihke b. (Middle) PIERCE c. (Last) BRASCHER				4. DATE OF DEATH (Month) (Day) (Year) 7 4 49			
5. SEX F. I		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH 4-17-1916	
9. AGE (In years last birthday) 32		10. MONTHS 2		11. BIRTHPLACE (State or foreign country) Chay Co. ARK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME James M. Pierce				13b. MOTHER'S MAIDEN NAME Nehh.ee Wilkies		14. NAME OF HUSBAND OR WIFE PAUL BRASCHER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give unit or dates of service) NO				16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME PAUL BRASCHER	
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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar pneumonia. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing 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 7-3, 1949, to 7-4, 1949 and I last saw the deceased alive on 7-3, 1949, and that death occurred at 8 A. M., from the causes and on the date stated above.							
23a. SIGNATURE D. Clifford				23b. ADDRESS Doniphan Mo.		23c. DATE SIGNED 7-6-49	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 7-6-49		24c. NAME OF CEMETERY OR CREMATORY Pratt Cemetery		24d. LOCATION (City, town, or county) (State) Ripley County MO	
DATE REC'D BY LOCAL REG. 7-6-49		REGISTRAR'S SIGNATURE E. B. Johnston		25. FUNERAL DIRECTOR'S SIGNATURE O. P. Schuman		ADDRESS CORNING 46 Ann	

(Licensed Embelmer's Statement on Reverse Side)

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

RECEIVED 8-6-49
District Health Officer No. 5,
District File Number 849565
Date Filed 8-8-49

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 _____

Signed _____
Student Embalmer

Licensed Embalmer No. 783 (ARK)

P. O. Address CORNING ARK

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.