

FILED AUG 24 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26393

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 60 PRIMARY REG. DIST. NO. 5235 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY <u>CEDAR</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>CEDAR</u>	
b. CITY OR TOWN <u>RURAL</u>		c. CITY OR TOWN <u>RURAL</u>	
c. LENGTH OF STAY (in this place) <u>77</u>		d. STREET ADDRESS (If rural, give location) <u>4 MILES NORTH WEST OF FRISCO, MO</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u> b. (Middle) <u>MAQDALENE</u> c. (Last) <u>BRASHER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>6-18-49</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>AUG 25, 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>lived on small farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>L</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>JOHN L BRASHER</u>		13b. MOTHER'S MAIDEN NAME <u>MARY RACHAEL LACY</u>	14. NAME OF HUSBAND OR WIFE <u>L</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>L</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Dr. Lammie S. Shepard</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>  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. <u>331X</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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>6-18, 1949</u> , to <u>6-18, 1949</u> , that I last saw the deceased alive on <u>6-18, 1949</u> , and that death occurred at <u>6 a. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Chanderwirth D.O.</u>		23b. ADDRESS <u>El Dorado Spgs</u>	23c. DATE SIGNED <u>6-21-49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. <u>June 30,</u>	REGISTRAR'S SIGNATURE <u>Mrs. Velma Ellis</u>	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS

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

RECEIVED  
District Health Officer No. 7,  
District File Number 7-44-1004  
Date Filed 9-22-49

**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 J. Bernard Bueing

Signed.....  
Student Embalmer

Licensed Embalmer No. 4161

P. O. Address Sheldon 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.