

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40523

State File No.

FILED JAN 11 1950

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

BIRTH NO. _____		REG. DIST. NO. <u>66</u>		PRIMARY REG. DIST. NO. <u>4116</u>		Registrar's No. <u>37</u>				
1. PLACE OF DEATH a. COUNTY <u>Chariton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Chariton</u>						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sumner</u>		c. LENGTH OF STAY (In this place) <u>40 yr</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sumner</u>		d. STREET ADDRESS (If rural, give location) <u>Cumbeingham Twp</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>✓</u>				d. STREET ADDRESS (If rural, give location) <u>Cumbeingham Twp</u>						
3. NAME OF DECEASED (Type or Print) a. (First) <u>Joseph</u>			b. (Middle) _____		c. (Last) <u>Brime</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 9 1949</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>Never Married</u>		8. DATE OF BIRTH <u>4/28 1867</u>		9. AGE (In years last birthday) <u>82</u> IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u> IF UNDER 12 HRS. Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>None (Mental Deficient)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Archbold Ohio O</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>John P Brime</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Roth</u>			14. NAME OF HUSBAND OR WIFE <u>none</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Nellie Howe</u>			ADDRESS <u>Sumner 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>A mental defect from birth</u> ANTECEDENT CAUSES <u>Very Pronounced Arterio Sclerosis</u> DUE TO (b) <u>and Interstitial Nephritis</u> DUE TO (c) <u>Very Chronic back Pressure to kidneys caused by Prostateal enlargement</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Prostateal enlargement</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Birth</u> <u>years</u> <u>57 1/2 X</u> <u>years</u>		
19a. DATE OF OPERATION <u>✓</u>		19b. MAJOR FINDINGS OF OPERATION <u>✓</u>						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) (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>Jan</u> , 19 <u>00</u> , to <u>1949</u> <u>12/9</u> 19 <u>49</u> , that I last saw the deceased alive on <u>12-7</u> , 19 <u>49</u> , and that death occurred at <u>9-4</u> a.m., from the causes and on the date stated above.										
23a. SIGNATURE <u>Dr Hardy D M D</u>				(Degree or title)		23b. ADDRESS <u>Sumner Mo</u>		23c. DATE SIGNED <u>12/9/49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>12/10/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Lake Side</u>		24d. LOCATION (City, town, or county) (State) <u>Sumner Mo</u>				
DATE REC'D BY LOCAL REG. <u>Dec 10 '49</u>		REGISTRAR'S SIGNATURE <u>Martha Clark</u>			57		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Kipard</u>		ADDRESS <u>Mendon Mo</u>	

RECEIVED

JAN 4

District Health Officer No. 8,

District File Number _____

Date Filed 1-10-50

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 L. L. Leipard

Signed _____
Student Embalmer

Licensed Embalmer No. 3970

P. O. Address Merdon, 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.