

FILED FEB 26 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4420

State File No.

0396

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

BIRTH NO. _____		REG. DIST. NO. <u>12C</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>140</u>	
1. PLACE OF DEATH a. COUNTY <u>CRAWFORD</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dallas</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>7 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Charity Mo.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>615 N Main</u>				d. STREET ADDRESS (If rural, give location) <u>Rural</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Amanda</u>		b. (Middle) <u>-</u>		c. (Last) <u>Brashear</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 20 1951</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>8-8-1866</u>	
9. AGE (In years last birthday) <u>84</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Dallas Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>David Holbert</u>		13b. MOTHER'S MAIDEN NAME <u>Amanda Oselsky</u>		14. NAME OF HUSBAND OR WIFE <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Jim Cline</u> ADDRESS _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Capillary Bronchitis</u>					
		ANTECEDENT CAUSES					
		DUE TO (b) <u>Diarrhoea 2 or 3 days</u>					
		DUE TO (c) <u>old left hemiplegia</u>				<u>352X</u>	
		II. OTHER SIGNIFICANT CONDITIONS					
		<u>Inanition</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) <u>no</u>		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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>one call on Feb 20, 1951</u> , that I last saw the deceased alive on <u>2/20, 1951</u> , and that death occurred at <u>10:10 P.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Garrett Hogg M.D.</u>				23b. ADDRESS <u>Springfield, Mo.</u>		23c. DATE SIGNED <u>2-23-51</u>	
24a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2/25/51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Charity</u>		24d. LOCATION (City, town, or county) (State) <u>Charity Mo.</u>	
DATE REC'D BY LOCAL REG. <u>2/23/51</u>		REGISTRAR'S SIGNATURE <u>W.E. Handley</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>L.B. Jones, Buffalo Mo</u>			

APR 6 1937

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.

Student
Student Embalmer

Signed Marion B Jones

Licensed Embalmer No. 4322

P. O. Address Buffalo, 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.