

FILED AUG 1 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23635**

BIRTH NO. _____ REG. DIST. NO. **184** PRIMARY REG. DIST. NO. **3038** Registrar's No. **53**

0582

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

1. PLACE OF DEATH a. COUNTY Linn		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Randolph	
b. CITY OR TOWN Brookfield		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Brookfield Hospital		c. CITY (If outside corporate limits, write RURAL and give township) Moberly d. STREET ADDRESS (If rural, give location) 401 Johnson St 1	
3. NAME OF DECEASED (Type or Print) a. (First) DONA b. (Middle) NELL c. (Last) PRIVETT		4. DATE OF DEATH (Month) (Day) (Year) July-15-1951	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June-29-1933
9. AGE (In years last birthday) 18		10. AGE (In years, months, days, hours, min.) — 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life (even if retired)) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Spickard Mo		12. CITIZEN OF WHAT COUNTRY U.S.A	
13a. FATHER'S NAME Lavern Hood		13b. MOTHER'S MAIDEN NAME Garnett Goldsby	
14. NAME OF HUSBAND OR WIFE William Privett		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mrs L Hood Spickard	
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) Traumatic cerebral hemorrhage INTERVAL BETWEEN ONSET AND DEATH 12 hrs ANTECEDENT CAUSES DUE TO (b) Automobile collision 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 058 E 816 E1 216	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) highway	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Linn Linn Mo		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 15, 12:30 AM	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? automobile collision	
22. I hereby certify that I attended the deceased from July 15, 1951 , to _____, 19____, that I last saw the deceased alive on July 15, 1951 , and that death occurred at 12 A. m. , from the causes and on the date stated above.			
23a. SIGNATURE W B Simpson MD		23b. ADDRESS Brookfield, Mo	
23c. DATE SIGNED 7/16/51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7/18-51	
24c. NAME OF CEMETERY OR CREMATORY Hall Rock Cemetery		24d. LOCATION (City, town, or county) (State) Mercer Mo	
DATE REC'D BY LOCAL REG. 7-23-51		REGISTRAR'S SIGNATURE J B Brown 167	
25. FUNERAL DIRECTOR'S SIGNATURE Scholar funeral Home Spickard Mo.		ADDRESS	

Date Received: JUL 30 1951
DISTRICT HEALTH OFFICE #2
District File Number 7-57-1350
Date Filed: JUL 30 1951

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 _____

Working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed J. H. Blacklock

Licensed Embalmer No. 2246

P. O. Address Brookfield 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.