

FILED AUG 23 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27867

BIRTH NO. _____		REG. DIST. NO. 278		PRIMARY REG. DIST. NO. 4413		Registrar's No. 176	
1. PLACE OF DEATH a. COUNTY <u>Pike</u> <u>0920</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>			
b. CITY OR TOWN <u>Frankford</u>		c. LENGTH OF STAY (in this place) <u>25 yrs</u>		c. CITY OR TOWN <u>Frankford</u> <u>0920</u>		d. STREET ADDRESS (If rural, give location) <u>(rural) Pens 0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) <u>SAMUEL</u> b. (Middle) <u>T.</u> c. (Last) <u>BRAYTON</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 6 1951</u>				
5. SEX <u>MO</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Feb 18 - 1883</u>	
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <u>Cedar Rapids, Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13a. FATHER'S NAME <u>John Brayton</u>			13b. MOTHER'S MAIDEN NAME <u>Irene</u>		14. NAME OF HUSBAND OR WIFE <u>Lillie Brayton</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. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Vaughn Harlinger</u> ADDRESS <u>Frankford</u>			
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c) _____		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteritis and arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH _____
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Heart trouble</u> DUE TO (c) <u>Kidney trouble</u>					
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 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) _____		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>Apr</u> , 19 <u>45</u> , to <u>Aug</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Aug 5</u> , 19 <u>51</u> , and that death occurred at <u>5 AM</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>E. P. Hansen DO.</u>				23b. ADDRESS <u>Frankford Mo</u>		23c. DATE SIGNED <u>Aug 7 1951</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug 8 - 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		24d. LOCATION (City, town, or county) <u>Frankford Mo.</u> (State) _____	
DATE REC'D BY LOCAL REG. <u>Aug 8, 1951</u>		REGISTRAR'S SIGNATURE <u>Berniece Collier</u> 374		25. FUNERAL DIRECTOR'S SIGNATURE <u>Fields</u> ADDRESS <u>Frankford Mo.</u>			

WRITE, PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

Date Received: **AUG 22 1951**  
DISTRICT HEALTH OFFICE #2  
District File Number *8-51-1475*  
Date Filed: **AUG 22 1951**

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**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.....

*Joe Silvio Ferguson*

Licensed Embalmer No. *4092*

P. O. Address *Washington No*

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.