

FILED NOV 17 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 339 PRIMARY REG. DIST. NO. 4502 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Pupeco</u>	c. LENGTH OF STAY (In this place) <u>year</u>	c. CITY OR TOWN <u>Pupeco</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Reagan Nursing Home</u>		e. STREET ADDRESS (If rural, give location) <u>Nov. 1954</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>CLAUDE</u> b. (Middle) <u>RAY</u> c. (Last) <u>BROWN</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Nov</u> <u>6</u> <u>1954</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>May 15, 1908</u>	9. AGE (In years last birthday) <u>46</u>	IF UNDER 1 YEAR Months _____	IF UNDER 1 YEAR Days _____	IF UNDER 1 Hrs. Hours _____	IF UNDER 1 Min. Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Timber</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Saw milling</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
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13a. FATHER'S NAME <u>Tom Brown</u>	13b. MOTHER'S MAIDEN NAME <u>Lessie Gore Skaggs</u>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Tom Brown, Fredenstrom, Mo.</u>	ADDRESS _____
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>BRONCHIAL PNEUMONIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>BRONCHIAL ASTHMA</u>		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>491X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) _____
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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? _____
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22. I hereby certify that I attended the deceased from Nov 1, 1954 to Nov 6, 1954, that I last saw the deceased alive on Nov 6, 1954, and that death occurred at 4:20 a. m., from the causes and on the date stated above.

23a. SIGNATURE <u>H. Skewes M.D.</u> (Degree or title)	23b. ADDRESS <u>Pupeco Mo</u>	23c. DATE SIGNED <u>11-9-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Nov. 7, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Magnor Memorial Park</u>	24d. LOCATION (City, town, or county), (State) <u>Advance, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>11/14/54</u>	REGISTRAR'S SIGNATURE <u>Paul Reed</u> <u>496</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. L. B. Magnor, Jr.</u> ADDRESS <u>Advance Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1030  
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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.....  
Signature of Student Embalmer

Signed..... *William H. Mason* .....

Licensed Embalmer No..... *46* .....

P. O. Address..... *Advance* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.