

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5393

State File No.

FILED MAR 7 1955

BIRTH NO. _____ REG. DIST. NO. 165 PRIMARY REG. DIST. NO. 5610 Registrar's No. 8

1. PLACE OF DEATH a. COUNTY <u>Johnson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>California</u> <u>Missouri</u> b. COUNTY <u>Johnson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural-Jefferson</u>		c. LENGTH OF STAY (in this place) <u>3 Min.</u>	c. CITY OR TOWN <u>Guerneville</u> <u>Sedalia AFB</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>6 Mi. N.W., Windsor, Mo.</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
STREET ADDRESS (If rural, give location) <u>Sedalia Air Force Base</u>		<u>0510</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>LESLIE</u>	b. (Middle) <u>HULETT</u>	c. (Last) <u>BROWN</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 23, 1955</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>Married</u>	8. DATE OF BIRTH <u>Dec. 19, 1915</u>	9. AGE (In years last birthday) <u>39</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Officer (Captain)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>US Air Force</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>San Francisco, California</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Leslie J. Brown</u>	13b. MOTHER'S MAIDEN NAME <u>Gladys M. Not Given</u>	14. NAME OF HUSBAND OR WIFE <u>Tristan R.</u>
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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>Yes Dec. 19, 1915</u>	16. SOCIAL SECURITY NO. <u>572-40-3207</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Sedalia AFB Records, Missouri</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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Multiple Injuries and Extensive burns as result of an unavoidable airplane Crash</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) _____		
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	<u>E860X</u> <u>39</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) <u>051</u> (COUNTY) _____ (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.	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 _____, 19____, to _____, 19____, that I last saw the deceased dead on 2/23/55, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <u>Kelly Rowland</u> (Degree or title) <u>M.D. Coroner</u>	23b. ADDRESS <u>Holden, Missouri</u>	23c. DATE SIGNED <u>2/25/55</u>
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24a. BURIAL (CREMATION, REMOVAL) (Specify) <u>Removal</u>	24b. DATE <u>Feb 26, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>148</u>	24d. LOCATION (City, town, or county) (State) <u>San Francisco, Calif.</u>
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DATE REC'D BY LOCAL REG. <u>2/26-55</u>	REGISTRAR'S SIGNATURE <u>Marnie D. Harker</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Keekart</u>	ADDRESS <u>Sedalia, Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

510
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RECEIVED
FEB 28 1955
JOHNSON COUNTY HEALTH DEPARTMENT

MAR 9 1955

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.....
W. Beckart

Licensed Embalmer No. *34*

P. O. Address *Sedalia*

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.