

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33017

State File No.

FILED OCT 24 1955

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 3025 Registrar's No. 89

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY OR TOWN <u>West Plains</u>		c. CITY OR TOWN <u>West Plains</u>	d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS (If rural, give location) <u>0411/0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Luna's Rest Home</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Mary</u>	b. (Middle) <u>Arnold</u>	c. (Last) <u>Brageal</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>10-14-55</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>Widowed</u>	8. DATE OF BIRTH <u>11-15-1875</u>	9. AGE (In years last birthday) <u>89</u>	10. IF UNDER 1 YEAR Months <u>10</u> Days <u>29</u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (City and State or Foreign Country) <u>Kentucky</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Ben Stacy</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Bone</u>	14. NAME OF HUSBAND OR WIFE <u>Tom Brageal</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME <u>Virgil Arnold</u> ADDRESS <u>Luna, Kans</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis Disease with Hemiplegia (RT)</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. (b) <u>curious or Febrile Dementia</u> (c) <u>Ac. Pulmonary Edema</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>331X</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) (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 11 Oct, 1955, to 14 Oct, 1955, that I last saw the deceased alive on 11 Oct, 1955, and that death occurred at 4:30 A. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Loeie H. ...</u>	(Degree of title) <u>MD</u>	23b. ADDRESS <u>West Plains, Mo</u>	23c. DATE SIGNED <u>17 1955</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	24b. DATE <u>10-16-55</u>	24c. NAME OF BEMETERY OR CREMATORY <u>Oak Lawn</u>	24d. LOCATION (City, town, or county) (State) <u>West Plains Mo</u>
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DATE REC'D BY LOCAL REG. <u>10-21-55</u>	REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>379</u> ADDRESS <u>Cherbon's West Plains, Mo</u>
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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 *DD Robertson*

Licensed Embalmer No. *34*

P. O. Address *West Plains*

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.