

FILED JAN 2 1957

STANDARD CERTIFICATE OF DEATH

40993
STATE FILE NUMBER

Registration District No. 96 Primary Registration District No. 5353 Registrar's No. 20

1. PLACE OF DEATH a. COUNTY Dallas		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Missouri b. COUNTY Dallas	
b. CITY (If outside corporate limits, give TOWNSHIP only) Jackson Twp.		c. CITY OR TOWN Elkland ^{30th}	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Residence		d. STREET ADDRESS RFD #1	
3. NAME OF DECEASED (Type or print) Joseph Hallic Breshears		4. DATE OF DEATH 12-25-1956	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-15-1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY own farm	11. BIRTHPLACE (City and state or country) Dallas County, Mo.
13. FATHER'S NAME Calvin Breshears		14. MOTHER'S MAIDEN NAME Catherine Silky	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT Mrs. Earl Palmer Address Elkland, Mo.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO (b) Arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Prostatitis - Chk. Hypertension			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION	COUNTY _____ STATE _____
21. I attended the deceased from 1957 to 12-23-56 and last saw him alive on 12-23-56 Death occurred at 2:35 P. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Paul O. Hammer MD		22b. ADDRESS Buffalo Mo.	22c. DATE SIGNED 12-21-56
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-27-56	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn	23d. LOCATION (City, town, or county) (State) Buffalo, Mo.
24. FUNERAL DIRECTOR L. B. Jones ADDRESS Buffalo, Mo.		25. DATE RECD. BY LOCAL REG. 12/31/56	26. REGISTRAR'S SIGNATURE The Grace Pettes

(Licensed Embalmer's Statement on Reverse Side)

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in reporting diseases in Part I must be causally related.

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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 em
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Gene C. Hunted*

Licensed Embalmer No. *47*

P. O. Address *Buffalo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.