

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAY 6 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16000

STATE FILE NUMBER

Registration District No. 373 Primary Registration District No. 6267 Registrar's No. 22

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| 1. PLACE OF DEATH a. COUNTY <u>WEBSTER</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WEBSTER</u> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jackson Township</u> | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN <u>ELKLAND</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | | Length of stay in 1b <u>3 Wks</u> | | d. STREET ADDRESS <u>1 mi. S. ELKLAND</u> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>BOBBIE ANN BRAKE</u> | | | | 4. DATE OF DEATH Month Day Year <u>April 24 1957</u> | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>FEB. 13, 1938</u> | | 9. AGE, (In years last birthday) <u>19</u> | | |
| | | | | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Missouri</u> | | |
| | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>William Brake</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Chloe Bryant</u> | | | | |
| 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>3532</u> | | 17. INFORMANT Address <u>William Brake, ELKLAND, MO.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Status epilepticus</u> DUE TO (c) <u>Epilepsy</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>about 2h.</u> <u>18 hours</u> <u>17 years</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) | | | | | | 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 Month, Day, Year a. m. p. m. | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY STATE | | |
| 21. I attended the deceased from <u>4:05 PM, 4/26/57</u> to <u>4:24 PM, 4/26/57</u> and last saw her alive on <u>4/26/1957</u> Death occurred at <u>4:24</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Sharon Zimmerman, D. Fair Grove, MO</u> | | | | 22b. ADDRESS <u>222b. ADDRESS</u> | | 22c. DATE SIGNED <u>4/29/57</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE <u>4/28/57</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MT. Pisgah</u> | | 23d. LOCATION (City, town, or county) <u>WEBSTER CO.</u> | | 23e. (State) <u>MO.</u> | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>BARBER Edwards MARSHFIELD, MO</u> | | | 25. DATE RECD. BY LOCAL REG. <u>5/3/57</u> | | 26. REGISTRAR'S SIGNATURE <u>J. Francis</u> | | | |

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 *George Stapp*
Licensed Embalmer No. 31

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

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.