

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **16070**

FILED MAY 28 1957

BIRTH NO. _____ REG. DIST. NO. 4 PRIMARY REG. DIST. NO. 5023 Registrar's No. 48

1. PLACE OF DEATH a. COUNTY Atchison		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Atchison- b. COUNTY Atchison ✓	
b. CITY OR TOWN Rural Clay Twsp.		c. CITY OR TOWN Rock Port. Mo., <i>en 30</i>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) none	
d. FULL NAME OF HOSPITAL OR INSTITUTION None			
3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Henderson c. (Last) Brown			4. DATE OF DEATH (Month) (Day) (Year) 5 7 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 1-7-1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	9. AGE (In years last birthday) 88 IF UNDER 1 YEAR: Months 4 Days 0 IF UNDER 24 HRS: Hours _____ Min. _____
11. BIRTHPLACE (State or foreign country) Morristown, Tenn.		12. CITIZEN OF WHAT COUNTRY? US	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs Alice Sleep Lamoni, Iowa. ADDRESS _____
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*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>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH 5 days ANTECEDENT CAUSES Cerebral Arterio sclerosis 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.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 332X	
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)			
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			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>53</u> , to <u>5-7</u> , 19 <u>57</u> , that I last saw the deceased <u>alive on 5-7-57</u> , and that death occurred at <u>8 P</u> m., from the causes and on the date stated above.			
23a. SIGNATURE Wallace Carpenter MD (Degree or title)		23b. ADDRESS Rock Port. Mo.	
23c. DATE SIGNED 5-21-57			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-11-1957	
24c. NAME OF CEMETERY OR CREMATORY Greenhill Cem.		24d. LOCATION (City, town, or county) (State) Rock Port. Mo.,	
DATE REC'D BY LOCAL REG. May 22, 1957		25. FUNERAL DIRECTOR'S SIGNATURE Bartholomew Mortuary, Rockport. ADDRESS _____	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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NOV 1958

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
Student Embalmer

Signed Gratz Bratholme

Licensed Embalmer No. 3173

P. O. Address Rock Port. Mo.,

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 this body is not embalmed, fact should be so stated above.