

FILED SEP 12 1957

STANDARD CERTIFICATE OF DEATH

State File No. 28735

BIRTH NO. REG. DIST. NO. 200 PRIMARY REG. DIST. NO. 5724 Registrar's No. 151

1. PLACE OF DEATH a. COUNTY Macon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Adair	
b. CITY (If outside corporate limits, write RURAL and give township) Rural, Eagle Twp.		c. CITY OR TOWN Brashear	d. Is 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) 0010	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 3 1/2 M. N. Macon			

3. NAME OF DECEASED (Type or Print) a. (First) OREN		b. (Middle) RAY		c. (Last) PETREE		4. DATE OF DEATH (Month) (Day) (Year) 8 28 1957	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH April 17, 1921	
9. AGE (In years last birthday) 36		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Hours		IF UNDER 15 MIN. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking		11. BIRTHPLACE (City and State or Foreign Country) Knox County Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Ray Petree		13b. MOTHER'S MAIDEN NAME Anice Lewis		14. NAME OF HUSBAND OR WIFE Louise Petree	
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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) No		16. SOCIAL SECURITY NO. 494-22-5896		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Louise Petree Brashear, Missouri	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Skull fracture		II. OTHER SIGNIFICANT CONDITIONS Automobile (truck) accident				Instant	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)		DUE TO (c)	

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 (Specify) SHOULDER X NECK X SKULL X		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 0 Macon Mo	
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21d. TIME OF INJURY 8 28 57 3 PM		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? Truck turned over	
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22. I hereby certify that I attended the deceased from **8/28** 19**57**, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **8:27** m., from the causes and on the date stated above.

23a. SIGNATURE Jessie E. Campbell MD (Degree of title)		23b. ADDRESS Macon Mo		23c. DATE SIGNED 8/31/57	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-31-1957		24c. NAME OF CEMETERY OR CREMATORY Gibbs Union		24d. LOCATION (City, town, or county) (State) Gibbs, Missouri	
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DATE REC'D BY LOCAL REG. 9/19/57		REGISTRAR'S SIGNATURE Ruth McNeely		5. FUNERAL DIRECTOR'S SIGNATURE R. Lester Bram		ADDRESS Macon Mo	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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SEP 17 1957

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County File No. 9.11.57
Date Filed

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 *R. Lester Bauer*

Licensed Embalmer No. 447

P. O. Address *Wilson*

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.