

Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. All symptoms will be listed. No standard nomenclature in item 18. 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.

FILED SEP 24 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31362

STATE FILE NUMBER

Registration District No. 110 Primary Registration District No. 4182 Registrar's No. 21

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN New Haven		c. CITY OR TOWN NEW HAVEN MO.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) WILLIAM		4. DATE OF DEATH Sept. 19 1957	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 6, 1873	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (City and state or country) New Haven Mo.	
13. FATHER'S NAME Herman Brune		14. MOTHER'S MAIDEN NAME Louisa Sprick	
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 Mr. Oscar Fetter New Haven Mo.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 Myocardial Degeneration Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 10 yrs.	
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 1:45 Month P. Day 2 Year 1957		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION New Haven, Missouri	
21. I attended the deceased from April 2, 1956 to Sept. 19, 1957 and last saw her alive on Sept. 17, 1957 Death occurred at 1:45 P. m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE M. H. Held (Degree or title) D.O.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-22-1957	
23c. NAME OF CEMETERY OR CREMATORY Beouf Luth Cem		23d. LOCATION (City, town, or county) (State) New Haven Mo.	
24. FUNERAL DIRECTOR L. C. Fertig & Son New Haven Mo.		25. DATE RECD. BY LOCAL REG. 9/22-1957	
26. REGISTRAR'S SIGNATURE Nellie Murphree			

MEDICAL CERTIFICATION

1966 6 2 100

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 *Carl O. Steig*

Licensed Embalmer No. *23*

P. O. Address *New York*

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.