

Health,
& Welfare
Public
Service

FILED SEP 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33021

STATE FILE NUMBER

Registration District No. 294

Primary Registration District No. 3056

Registrar's No. 218

5. 300
1-57

1. PLACE OF DEATH a. COUNTY - b. CITY (If outside corporate limits, give TOWNSHIP only) Randolph OR TOWN Moberly c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Whittaker Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Randolph c. CITY OR TOWN Moberly d. STREET ADDRESS 214 1/2 S. 4th	
3. NAME OF DECEASED (Type or print) First Middle Last Minnie Kate Brown			4. DATE OF DEATH Month Day Year 8 31 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 / 7 / 1880
9. AGE (In years last birthday) 86		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home making	11. BIRTHPLACE (City and state or country) Holliday, Monroe Co Mo
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Thomas J Barker	13b. MOTHER'S MAIDEN NAME Sarah Dawson
14. NAME OF HUSBAND OR WIFE Joel Brown		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 Mrs. Clyde DeLaney		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>Sepsis</u> DUE TO (b) <u>Pneumonia</u> DUE TO (c) _____ PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Non union of intratrochanteric fracture of the femur</u>	
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 <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 Holliday		COUNTY : STATE	
21. I attended the deceased from 7/2/55 to 8/31/57 and last saw her alive on 8/31/57 Death occurred at 6.30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) E. T. Whitaker Do.		22b. ADDRESS 205 S. Fifth St., Moberly	
22c. DATE SIGNED 9/3/57		23a. BURIAL, CREMATION, REMOVAL (Specify) burial	
23b. DATE Sept 3		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	
23d. LOCATION (City, town, or county) Holliday, Missouri		23e. (State)	
24. FUNERAL DIRECTOR Fred A Thompson		25. DATE RECD. BY LOCAL REG. Sept 3/57	
ADDRESS Madison, Mo		26. REGISTRAR'S SIGNATURE Seaborn	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Mr. Fred C. Kumpf*

Licensed Embalmer No. *3282*
P. O. Address *Madison*

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.