

FILED NOV 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37057
STATE FILE NUMBER

Registration District No. 814 Primary Registration District No. 4457 Registrar's No. 62

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>St; Clair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> <u>St; Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Osceola Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Collins</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Osceola Hospital</u>		Length of stay in lb <u>2 Weeks</u>	d. STREET ADDRESS (If outside, give location) <u>420</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>W.</u> Last <u>Brinegar</u>			4. DATE OF DEATH <u>Oct; 27, 1957</u> Month Day Year
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb; 2, 1876</u>
9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Bentonville Arkansas</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Thomas Brinegar</u>	
13b. MOTHER'S MAIDEN NAME <u>Lottie Francis</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</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>None</u>	17. INFORMANT Address <u>W.B. Brinegar, Collins Missouri</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>Cerebral thrombosis</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>332X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>years</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 <input type="checkbox"/> WORK AT WORK		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION <u>Osceola MO</u>		COUNTY STATE	
21. I attended the deceased from <u>1 July 56</u> to <u>27 Oct 57</u> and last saw him alive on <u>27 Oct 57</u> Death occurred at <u>P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>H. L. Casler MD</u> (Degree or title)		22b. ADDRESS <u>Osceola MO</u>	
22c. DATE SIGNED <u>28 Oct 57</u>		23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>	
23b. DATE <u>10-30-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Robinson</u>	
23d. LOCATION (City, town, or county) <u>Collins Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>Goodrich 7-HOME OSCEOLA MO 11-2-57</u>		25. DATE RECD. BY LOCAL REG. <u>11-2-57</u>	
26. REGISTRAR'S SIGNATURE <u>Frank Seever</u>			

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 *J.B. Goodrich*

Licensed Embalmer No. *3038*

P. O. Address *Osceola W.V.*

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.