

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43894

STATE FILE NUMBER

FILED JAN 7 1958

Registration District No. 93

Primary Registration District No. 5340

Registrar's No. 57-95

S. 300  
v. 1-56

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Dade				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Dade			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Smith TWP			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Lockwood Mo Rt3		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4mi. S.E.			Length of stay in 1b Pyrs	d. STREET ADDRESS 4mi.S.E.			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Melvin LeRoy Birran			4. DATE OF DEATH Month Day Year Dec. 24 1957				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 11, 1889	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months Days Hours Min. 8 13	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired oil field worker			10b. KIND OF BUSINESS OR INDUSTRY oil fields	11. BIRTHPLACE (City and state or country) Osage Iowa		12. CITIZEN OF WHAT COUNTRY? usa	
13. FATHER'S NAME Samuel A Birran				14. MOTHER'S MAIDEN NAME Dela Haight			
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. 442-07-7400A		17. INFORMANT Address Mrs Miriam C Birran Lockwood Mo rt3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i>							INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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 WORK <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		COUNTY STATE	
21. I attended the deceased from <i>10-2-57</i> to <i>12-24-57</i> and last saw <i>him</i> alive on <i>12-12-57</i> Death occurred at <i>7:00A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Max Heilbrunn MD</i>				22b. ADDRESS <i>Lockwood, Mo</i>		22c. DATE SIGNED <i>12-26-57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE <i>Dec. 27, 1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Lockwood</i>		23d. LOCATION (City, town, or county) (State) <i>Lockwood Mo</i>		
24. FUNERAL DIRECTOR ADDRESS <i>W.R. Allin Greenfield Mo.</i>			25. DATE RECD. BY LOCAL REG. <i>12/30/1957</i>		26. REGISTRAR'S SIGNATURE <i>J. C. Canada</i>		

(Licensed Embalmer's Statement on Reverse Side)

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 *W.R. Allison* .....

Licensed Embalmer No. *440*

P. O. Address *Greenfield*

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.