

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032485

STATE FILE NUMBER

FILED OCT 6 1958 Registration District No. 143 Primary Registration District No. 4557 Registrar's No. 31

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Pomona</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Pomona</u> 0460		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <input checked="" type="checkbox"/>			Length of stay in 1b <input checked="" type="checkbox"/> 40 yrs		d. STREET ADDRESS (If outside, give location) <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Simon Brownfield</u>				4. DATE OF DEATH Month Day Year <u>9-5-1958</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-6-1878</u>		9. AGE (In years last birthday) <u>77</u>	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when first started) <u>Retired K K Employee</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Ottumwa, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John Brownfield</u>			13b. MOTHER'S MAIDEN NAME <u>Punlan</u>		14. NAME OF HUSBAND OR WIFE <u>Maude Brownfield</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Maude Brownfield</u> Address <u>Pomona, MO</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>Cerebrovascular accident</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>cerebral hemorrhage</u>					<u>10 days</u>		
		DUE TO (c) <u>Generalized arteriosclerosis</u>					<u>5 yrs</u>		
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"/>		
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.) <u>331X</u>						
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		COUNTY		STATE	
21. I attended the deceased from <u>8/29/58</u> to <u>9/5/58</u> and last saw ^{them} him alive on <u>8/29/58</u> Death occurred at <u>5:10 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>M. L. Janda MD</u>				22b. ADDRESS <u>West Plains MO</u>		22c. DATE SIGNED <u>9/12/58</u>			
23a. BURIAL, CREMATION, REBURYAL (Specify)		23b. DATE <u>9-8-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mickey</u>		23d. LOCATION (City, town, or county) (State) <u>Pomona MO</u>				
24. FUNERAL DIRECTOR <u>Richardson's Mortuary</u>			ADDRESS <u>West Plains</u>		25. DATE RECD. BY LOCAL REG. <u>9/30/58</u>		26. REGISTRAR'S SIGNATURE <u>Marcelle Ballard</u>		

All diseases in Part I must be causally related.
 Medical certification
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 No symptoms will be listed.

MS JUN 23 1959

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 *A. A. Roberts*

Licensed Embalmer No. *3430*
P. O. Address *West Hill*

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.