Health, & Welfare Public Service

S. 300 1
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-040820
STATE FILE NUMBER

FILED DEC 9 1958 Registration District No. 234 Primary Registration District No. 4349 Registrar's No. 30

1. PLACE OF DEATH
a. COUNTY: MORGAN
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: STOVER — Inside Limits: Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 1ST. STREET — Length of stay in 1b: 3 YRS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: MORGAN
c. CITY OR TOWN: STOVER — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 1st. STREET — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: MARION Middle: Last: BRADEN

4. DATE OF DEATH: Month NOV. Day 26 Year 1958

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: NOV. 22 1880
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months 0 Days 4 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARM
10b. KIND OF BUSINESS OR INDUSTRY: FARM
11. BIRTHPLACE (City and state or country): MORGAN COUNTY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: JOHN BRADEN
13b. MOTHER'S MAIDEN NAME: MARTHA BRADSHAW
14. NAME OF HUSBAND OR WIFE: FEEBIE BRADEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: FEEBIE BRADEN Address: STOVER MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Coronary artery Occlusion
DUE TO (c): Arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH: Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4201
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 May 20, 1958 to Nov 26, 1958 and last saw him alive on Nov 14, 1958
Death occurred at 5:15 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: H. A. Koffa (Degree or title) D.O.
22b. ADDRESS: Stover, Mo
22c. DATE SIGNED: 11/29/58

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: NOV. 30 1958
23c. NAME OF CEMETERY OR CREMATORY: SHILO CEMETERY
23d. LOCATION (City, town, or county) (State): MORGAN COUNTY Mo

24. FUNERAL DIRECTOR: J. H. Stevinson ADDRESS: Stover Mo.
25. DATE RECD. BY LOCAL REG.: Dec 3-1958
26. REGISTRAR'S SIGNATURE: Wm. L. Reppenger

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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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. L. Stevinson

Licensed Embalmer No. 4073

P. O. Address Stover Mo

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.