

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043580

STATE FILE NUMBER

FILED JAN 13 1959

Registration District No. 74

Primary Registration District No. 5293

Registrar's No. 48

S. 300
1-57

1. PLACE OF DEATH a. COUNTY Clinton		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Clinton	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Atchison TWP.		c. CITY OR TOWN Gower	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Residence		d. STREET ADDRESS (If outside, give location) R.F.D.#1	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM E. BRINION		4. DATE OF DEATH Month Day Year Dec. 29, 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farming	11. BIRTHPLACE (City and state or country) Buchanan Co., Mo.
13a. FATHER'S NAME William Brinton		13b. MOTHER'S MAIDEN NAME Sarah Powell	14. NAME OF HUSBAND OR WIFE Anna L. Brinton
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. 496-42-3169	17. INFORMANT Address Anna L. Brinton Gower, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Scarlet Fever DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4222			INTERVAL BETWEEN ONSET AND DEATH 7 yrs 9 yrs
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.) 4222	
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 Mar 5-1957 and last saw her alive on Dec 29-58 Death occurred at 6:20 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) W. B. Shalburg MD		22b. ADDRESS Plattsburg Mo	
22c. DATE SIGNED 12-31-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 12/30/1958	
23c. NAME OF CEMETERY OR CREMATORY Frazier Cemetery		23d. LOCATION (city, town, or county) (State) Buchanan Co. Mo.	
24. FUNERAL DIRECTOR John H. Murray		25. DATE RECD. BY LOCAL REG.	
ADDRESS Gower, Mo.		26. REGISTRAR'S SIGNATURE Pauline Chaney (Deputy)	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Me*....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *John H. Murray*.....

Licensed Embalmer No. *3893*.....
P. O. Address *Gower 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.