

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044820

STATE FILE NUMBER

FILED DEC 29 1958 Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 288

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1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Chillicothe</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital</u>		Length of stay in lb <u>50 years</u>	d. STREET ADDRESS (If outside, give location) <u>1301 Third Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Amanda</u> Middle <u>Elizabeth</u> Last <u>Brookshire</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>19</u> Year <u>1958</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>20 Oct. 1878</u>	9. AGE (In years) <u>80</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Sampsel, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Joshua Walker</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Jane Dawkins</u>	14. NAME OF HUSBAND OR WIFE <u>Norris Wade Brookshire</u>
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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 <u>Mrs. C. G. Updyke</u> Address <u>1301 Third Street Chillicothe, Missouri</u>
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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>Pneumonia</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) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>① Hypertension ② Abdominal aortic aneurysm</u> <u>491X</u>		

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.)
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20c. TIME OF INJURY Hour _____ 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 _____
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21. I attended the deceased from _____ 19 <u>47</u> to 19 <u>58</u> and last saw her alive on <u>19 Dec. 1958</u> . Death occurred at <u>eight fifty</u> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Sign or title) <u>Charles M. Hale, M.D.</u>	22b. ADDRESS <u>Chillicothe, Mo.</u>	22c. DATE SIGNED <u>20 Dec 1958</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-22-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Edgewood</u>	23d. LOCATION (City, town, or county) (State) <u>Chillicothe Missouri</u>
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24. FUNERAL DIRECTOR <u>Norman Funeral Home</u> ADDRESS <u>Chillicothe, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-20-58</u>	26. REGISTRAR'S SIGNATURE <u>Frances B Neill</u>
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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.

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Elton F. Norman*

Licensed Embalmer No. *4036*
P. O. Address *Chillicothe,*

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.