

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004782

STATE FILE NUMBER

FILED MAR 9 1959

Registration District No. 55 Primary Registration District No. 5190 Registrar's No. 15

300
-57

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CARROLL</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CARROLLTON, CARROLLTON TWP</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>BOSWORTH</u> <u>C178</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>1 M. N. Bosworth, Mo</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clemma Brown</u>			4. DATE OF DEATH Month Day Year <u>Feb 24 1959</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 2 - 1878</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician's wife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (In years last birthday) <u>81</u> IF UNDER 1 YEAR Months Days <u>9</u> IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician's wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>GOLD HILL NEVADA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Isaac M. Fruck</u>	
13b. MOTHER'S MAIDEN NAME <u>KATHRYN NEICHTER</u>		14. NAME OF HUSBAND OR WIFE <u>DECEASED</u>	
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>DR. WILSON BROWN</u> Address <u>3518 WEST RIDGE, ZONE 25 HOUSTON TEXAS</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>CRUSHED CHEST, BROKEN NECK, FRACTURED LEFT LEG</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>CAR Accident 1 1/4 mile EAST of CARROLLTON CAR STEEL BRIDGE</u> DUE TO (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>ABRASIONS OF RIGHT AND LEFT LEG. BROKEN NOSE</u>			19. INTERVAL BETWEEN ONSET AND DEATH <u>AT ONCE</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20a. ACCIDENT <input checked="" 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>1 CAR AUTO ACCIDENT 1 1/4 MILE EAST OF CARROLLTON</u>	
20c. TIME OF INJURY Hour Month, Day, Year <u>4:45 p.m. 2-24-59</u>		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.) <u>CARROLLTON (near CARROLL</u>		20f. CITY, TOWN, OR LOCATION <u>CARROLL</u> STATE <u>Missouri</u>	
21. I attended the deceased from <u>2-24-59</u> , to <u>2-24-59</u> and last saw her alive on <u>D.O.A.</u> Death occurred at <u>4:45</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>P. Monahan, Jr. Coroner</u> (Degree or title) <u>3</u>		22b. ADDRESS <u>Carrollton Mo</u>	
22c. DATE SIGNED <u>2-24-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>FEB 27, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ELIZABETH CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>5M-N-BOSWORTH MO</u>
24. FUNERAL DIRECTOR <u>LEIPARD & EDWARDS</u>		25. DATE RECD. BY LOCAL REG. <u>3-2-59</u>	26. REGISTRAR'S SIGNATURE <u>Mr. Herbert Caldwell</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAR 9 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 *David J. Edwards*

Licensed Embalmer No. *3265*

P. O. Address *Bonworth 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.