

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004852

STATE FILE NUMBER

FILED MAR 6 1959 Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 21

1. PLACE OF DEATH a. COUNTY <b>Clay</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Ray</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Excelsior Springs</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Excelsior Springs</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Excelsior Spring Hospital</b>		Length of stay in lb <b>23 days</b>	d. STREET ADDRESS (If outside, give location) <b>RR# 2</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Bosworth</b> Last <b>Brown</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>17</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 16, 1883</b>		9. AGE (In years last birthday) <b>76</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stationary Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>St. Lukes Hospital</b>	11. BIRTHPLACE (City and state or country) <b>Plattsmouth, Nebraska</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>William B. Brown</b>		13b. MOTHER'S MAIDEN NAME <b>Alletta Masters</b>		14. NAME OF HUSBAND OR WIFE <b>Mabel Weaver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>486-10-1145</b>	17. INFORMANT Address <b>Mrs. Mabel Brown, Excelsior Springs, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chronic organizing pneumonia</b>					<b>3 wks</b>
DUE TO (c) <b>Bullous emphysema</b>					<b>7-10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic adhesive pericarditis</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)		
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 <b>1953</b> to <b>17 Feb 1959</b> and last saw <sup>him</sup> alive on <b>17 Feb 1959</b> Death occurred at <b>6:15 p.m.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>George E. Sanders M.D.</b>			22b. ADDRESS <b>Excelsior Springs, Mo.</b>		22c. DATE SIGNED <b>2-19-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-21-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Moriah</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Prichard Funeral Home, Inc.</b>			25. DATE RECD. BY LOCAL REG. <b>2/19/59</b>	26. REGISTRAR'S SIGNATURE <b>Baroline Hatcher</b>	

Excelsior Springs, Missouri

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Health, Welfare, Public Service

300  
-57

Doctor, coroner, etc. must use only standard nomenclature in report to health officer. All diseases in Part I must be causally related.



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 *Ralph Van Landingham* .....

Licensed Embalmer No. *4229*....  
P. O. Address *Chelton Springs, Md*

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.