

Health,  
Welfare  
Public  
Service

XC-116 032  
SL 17593

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010735  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **2443**

**MAR 25 1959**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>PHELPS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N. GRAND, ST. LOUIS, MO.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ROLLA</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET. ADM. HOSPITAL</b>		Length of stay in lb <b>203 days</b>	d. STREET ADDRESS (If outside, give location) <b>1200 PINE ST.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>F.</b> Last <b>BRANT</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>9</b> Year <b>1959</b>		
--	--	--	--	--	--

5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/31/95</b>	9. AGE (In years last birthday) <b>64</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
-----------------------	----------------------------------	---	------------------------------------	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>CHILLICOTHE, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
---	-----------------------------------	--	--

13a. FATHER'S NAME <b>GEORGE T. BRANT</b>	13b. MOTHER'S MAIDEN NAME <b>AGNES KROPPLER</b>	14. NAME OF HUSBAND OR WIFE -----
--	--	--------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>YES</b> <b>1941-1945</b>	16. SOCIAL SECURITY NO. <b>500-16-3889</b>	17. INFORMANT <b>VA HOSP. RECORDS, ST. LOUIS, MO.</b> Address
---	---	---

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>Pulmonary embolus, left pulmonary artery</b>		INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b>
Tuberculosis fibrocaceous minimal to moderate, left upper lobe DUE TO (b) <b>002X</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>a) Status following right pneumonectomy, 1 month;</b> <b>b) Abscess of skin and subcutaneous tissue, thoracotomy incision</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 _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <b>ROLLA, MO.</b>	COUNTY <b>PHELPS</b>	STATE <b>MISSOURI</b>
---	---	--	---	-------------------------	--------------------------

21. <input checked="" type="checkbox"/> attended the deceased from <b>8/18/58</b> to <b>3/9/59</b> and last saw <sup>him</sup> <b>him</b> alive on <b>3/9/59</b> Death occurred at <b>3:30 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE <i>Marvyn R. Reed, M.D.</i> (Degree or title)	22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>	22c. DATE SIGNED <b>3/9/59</b>
---	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3-11-59</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <b>Rolla, Mo.</b>
---	-----------------------------	------------------------------------	--

24. FUNERAL DIRECTOR <b>Albert H. Hoppe 4700 Washington, Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 9 '59</b>	26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>
---	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAR 8 5 1959

MAR 30 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, ~~by~~ ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Elton H. Penelias* .....

Licensed Embalmer No. *4283* .....

P. O. Address *St. Louis, 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.