

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020261

STATE FILE NUMBER

FILED JUL 13 1959 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 205

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Knox</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Novelty</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Grim-Smith Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>520 S</u>	
Length of stay in lb <u>15 days</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>HERBERT</u> Middle <u>EARNEST</u> Last <u>BROWNING</u>			4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1959</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>Sept 9, 1880</u>		9. AGE (In years) <u>78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret. farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Macon County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Samuel A. Browning</u>		13b. MOTHER'S MAIDEN NAME <u>Parley Gentry</u>		14. NAME OF HUSBAND OR WIFE <u>Lillie E. Doyle</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>497-10-1320</u>		17. INFORMANT <u>Otis Browning</u> Address <u>Clarence, Mo</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>Coronary embolus</u>		INTERVAL BETWEEN ONSET AND DEATH
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>Retropubic prostectomy.</u>		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.) _____	
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 6-5-59 to 6-20-59 and last saw ~~him~~ ^{her} alive on 6-20-59
Death occurred at 2:25 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degen or title) <u>Milton T. Engler M.D.</u>		22b. ADDRESS <u>Kirksville, Missouri</u>		22c. DATE SIGNED <u>6-20-59</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>23 June '59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>La Plata Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>La Plata, Missouri</u>	
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24. FUNERAL DIRECTOR <u>A. B. Pinner</u>		ADDRESS <u>Edina, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>6-21-59</u>		26. REGISTRAR'S SIGNATURE <u>Doris W. Ratliff</u>	
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HUDSON FUNERAL HOME (Licensed Embalmer's Statement on Reverse Side) 7-9-1959

st. Health,
, & Welfare
S. Public
th Service

S. 300
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securing the medical certification in the specific manner required by 193.140 MORS 1957.
 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.
 F&G 41514 M.D.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MILTON T.

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 *A. J. Rimer*

Licensed Embalmer No. *5041*

P. O. Address *Edina, 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.