

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-020566

FILED JUL 14 1959 44

Registration District No. _____ Primary Registration District No. 4260 Registrar's No. 12

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY CALDWELL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY VERNON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN BRECKENRIDGE		Length of stay in 1b 1 MONTH	c. CITY OR TOWN SHELDON
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION RESIDENCE		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) NONE
		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First FLORA Middle BELLE Last BRIGHT			4. DATE OF DEATH Month JULY Day 4 Year 1959		
5. SEX FEMALE	6. COLOR OR RACE CAUC.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH JUNE 14, 1869	9. AGE (last birthday) 90	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) OHIO	12. CITIZEN OF WHAT COUNTRY U.S.A.	

13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE DECEASED	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT CAROLINE BRIGHT BRECKENRIDGE Mo.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) medullary failure		seconds
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral thrombosis	13 days
	DUE TO (c) Cerebral arteriosclerosis	years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertension, Previous cerebral thrombosis		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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 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 SHELDON	COUNTY _____ STATE _____
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21. I attended the deceased from **Feb 10, 1959** to **July 3, 59** and last saw her alive on **July 4, 1959**
Death occurred at **1:35** **AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Shwoodlight Do	22b. ADDRESS Breckenridge Mo	22c. DATE SIGNED 7/9/59
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE JULY 4, 1959	23c. NAME OF CEMETERY OR CREMATORY UNKNOWN
24. FUNERAL DIRECTOR HEAD-PTS	ADDRESS BRECKENRIDGE Mo	25. DATE RECD. BY LOCAL REG. 7-6-59
		26. REGISTRAR'S SIGNATURE Mrs. Ruth Ann Ziggart

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Bernard F. M.

Licensed Embalmer No. 2891
P. O. Address Box 245 BR

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.