

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020601

STATE FILE NUMBER

FILED JUL 15 1959 Registration District No. 47 Primary Registration District No. 5166 Registrar's No. 185

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cole</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Auxvasse</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Jefferson City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Biggers Nursing Home</u>		Length of stay in 1b <u>11 Mo.</u>	d. STREET ADDRESS (If outside, give location) <u>426 1/2</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>West</u> Last <u>Brooks</u>			4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>July 10 - 1880</u>	9. AGE (In years last birthday) <u>78</u>	FUNDER 1 YEAR Months <u>11</u> Days <u>24</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTH PLACE (City and state or country) <u>Callaway Co. MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Abner T. Johnson</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Boyd</u>		14. NAME OF HUSBAND <u>Elmer West Brooks</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>499-24-9220</u>	17. INFORMANT Address <u>Mrs R.C. Johnson, Seltette 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>Myocardial Infarction</u> DUE TO (b) <u>Coronary Vascular Renal Syndrome</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>Sent Seltette</u>					INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u>
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.) <u></u>			
20c. TIME OF INJURY Hour <u></u> Month, Day, Year a.m. <u></u> p.m. <u></u>					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u></u>	
21. I attended the deceased from <u>Sept 58</u> to <u>July 4-59</u> and last saw her alive on <u>July 2-59</u> Death occurred at <u>6 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Martha Lawrence</u> (Degree or title) <u>2</u>			22b. ADDRESS <u>Auxvasse Mo.</u>		22c. DATE SIGNED <u>7-4-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 5-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Hartsburg MO</u>
24. FUNERAL DIRECTOR <u>Claypool Scr. New Bloomfield</u>		ADDRESS <u></u>		25. DATE RECD. BY LOCAL REG. <u>7 July 1959</u>	26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>

(Licensed Embalmer's Statement on Reverse Side)
MO.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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4-4
10-7
1980
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95-11-

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 *LeRoy Claypool*

Licensed Embalmer No. *4412*

P. O. Address *New Bloomfield*

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.