

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022096

Filed JUN 29 1959 Registration District No. 385 Primary Registration District No. 3039 STATE FILE NUMBER 53 Registrar's No. 53

1. PLACE OF DEATH a. COUNTY Linn		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo COUNTY Linn	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marceline		c. CITY OR TOWN Marceline	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Florence Rest Home		d. STREET ADDRESS (If outside, give location) 108 W. Walker	

3. NAME OF DECEASED (Type or print) First William Middle E. Last Branic			4. DATE OF DEATH Month 6 Day 12 Year 1959		
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5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/7/1865	9. AGE (In years last birthday) 94	IF UNDER 1 YEAR Months 3 Days 5 Hours Min. 	IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Union Pacific	10b. KIND OF BUSINESS OR INDUSTRY R.R. Retired	11. BIRTHPLACE (City and state or country) Shelby Co. Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Bessie
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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 Bessie Branic Marceline, Mo.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 1 day months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerosis & hypertension	
	DUE TO (c) Chronic Bronchiectasis	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Bronchiectasis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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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 Marceline	COUNTY Linn	STATE Mo
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21. I attended the deceased from 5/9/59 to 6/12/59 and last saw ^{him} her alive on 6/12/59 Death occurred at 6:20 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) John Otto Carr, Jr. M.D.	22b. ADDRESS Marceline	22c. DATE SIGNED 6/13/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) B	23b. DATE 6/14/1959	23c. NAME OF CEMETERY OR CREMATORY Asbury	23d. LOCATION (City, town, or county) Keytesville, Mo.	(State)
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24. FUNERAL DIRECTOR James McLaughlin	ADDRESS Marceline, Mo.	25. DATE RECD. BY LOCAL REG. 6-21-59	26. REGISTRAR'S SIGNATURE Brookie Owens
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 James B Mc Clelland

Licensed Embalmer No. 4230

P. O. Address Brookfield Me

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.