

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026227

FILED VS AUG 17 1959

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 169

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Randolph</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Randolph</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Moberly</u>		Length of stay in 1b <u>2 months</u>		c. CITY OR TOWN <u>Rural--Salt Spring Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wabash Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>about 1 mi. W. of Huntsville</u>			
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>Summers</u> Last <u>Bragg</u>			4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1959</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12-14-1890</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wabash Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wabash RR</u>		11. BIRTHPLACE (City and state or country) <u>Jacksonville, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>United States</u>	
13a. FATHER'S NAME <u>Dr. G.G. Bragg</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Summers</u>		14. NAME OF HUSBAND OR WIFE <u>Xena Kingsbury Bragg</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>723-09-1617</u>		17. INFORMANT Address <u>Mrs. Herman Bragg: Huntsville, Missouri</u>			
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) <u>Widespread carcinomatosis</u>							<u>5 weeks(?)</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Metastatic Adenocarcinoma</u>							<u>Unknown</u>
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input 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.	Month, Day, Year _____						
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		COUNTY	STATE
21. I attended the deceased from <u>June 1, 1959</u> to <u>August 1, 1959</u> and last saw him alive on <u>August 1, 1959</u> Death occurred at <u>3:30 P. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u> (Degree or Title) <u>MD</u>				22b. <u>Wabash Employees Hospital</u>		22c. DATE SIGNED <u>AUG 3 1959</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>8-3-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Huntsville Cemetery</u>		23d. LOCATION (City, town, or county) <u>Huntsville, Missouri</u>		(State)
24. FUNERAL DIRECTOR <u>Tom Patton</u> ADDRESS <u>Huntsville</u>			25. DATE RECD. BY LOCAL REG. <u>8-3-59</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 26 1959

AUG 18 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 _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Tom B Patton

Licensed Embalmer No. 3914
P. O. Address Hunter

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.