

FEDERAL BUREAU OF INVESTIGATION
 DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027971

INDEXED

SEP 14 1959

Registration District No. 1 Primary Registration District No. 300 Registrar's No. 275 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Shelby	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville, Mo		Length of stay in 1b	c. CITY OR TOWN Shelbyville, Mo
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Laughlin Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Dovie Middle Virginia Last Brown	4. DATE OF DEATH Month September Day 2 Year 59
--	--

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/12/70	9. AGE (last birthday) 89	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
----------------------	-------------------------------	---	---------------------------------	----------------------------------	---	------------------------------

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) Nelsonville, Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	-----------------------------------	--	--

13a. FATHER'S NAME John Schofield	13b. MOTHER'S MAIDEN NAME Allie Smith	14. NAME OF HUSBAND OR WIFE Lee Brown
---	---	---

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 Harry Vanskike	Address Shelbyville
---	--	--	-------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism	INTERVAL BETWEEN ONSET AND DEATH 20 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic cor pulmonale	unknown
DUE TO (c) Congestive heart failure	unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Inter trochanteric fracture of rt. femur	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 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 **Aug. 21, 1959** to **Sept. 2, 1959** and last saw her alive on **Sept. 2, 1959**
 Death occurred at **10:30 A.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Jack Hunter	22b. ADDRESS Kirksville, Mo.	22c. DATE SIGNED 9.4.59
--	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/4/59	23c. NAME OF CEMETERY OR CREMATORY Shiloh Cemetery	23d. LOCATION (City, town, or county) Shelby	(State) Mo
--	----------------------------	--	--	----------------------

24. FUNERAL DIRECTOR C.W. Musgrove	ADDRESS Bethel, Mo	25. DATE RECD. BY LOCAL REG. 9-9-1959	26. REGISTRAR'S SIGNATURE Doris W. Pottloff
--	------------------------------	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 16 1959

OCT 30 1959

JACK AUSTER, D.O.

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 Self Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Lawrence

Licensed Embalmer No. 2719

P. O. Address Bethel Mo

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.