

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 1 1959

59-028021

Registration District No. 4 Primary Registration District No. _____ Registrar's No. 79

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Atchison</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Atchison</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fairfax</u>		Length of stay in 1b <u>4 days</u>		c. CITY OR TOWN <u>Fairfax</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>Community Hospital</u>		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 <u>HAZEL</u> Middle <u>*****</u> Last <u>BRYAN</u>				4. DATE OF DEATH Month <u>August</u> Day <u>26</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>9/17/1886</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Postoffice</u>		11. BIRTHPLACE (City and state or country) <u>Fairfax Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Theodore Miller</u>		13b. MOTHER'S MAIDEN NAME <u>Charlotte Volker</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</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>*****</u>		17. INFORMANT <u>James Miller</u> Address <u>Fairfax 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>Cerebro-Vascular Accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Thrombosis</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>Aug 1, 1959</u> to <u>Aug 26, 1959</u> and last saw her <u>her</u> alive on <u>Aug 26, 1959</u> Death occurred at <u>5:30</u> <u>P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>J. F. Sweeney, M.D.</u> (Degree or title)				22b. ADDRESS <u>Oregon, MO</u>		22c. DATE SIGNED <u>8-27-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8/28/59</u>		23c. NAME OF CEMETERY OR INTERMENT PLACE <u>Pleasant Ridge</u>		23d. LOCATION (City, town, or county) (State) <u>Fairfax Mo.</u>	
24. FUNERAL DIRECTOR <u>Schooler Funeral Home</u>		ADDRESS <u>Fairfax Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 27, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Marvin N. Schaefer</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 8 1961

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

Thermin H. Schoale

Licensed Embalmer No. *4162*

P. O. Address *Fairfax*

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.