

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028211

FILED VS AUG 24 1959

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846

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Doniphan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 2 Days	c. CITY OR TOWN Elwood Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 703 Kentucky Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Frank Middle _____ Last Brown			4. DATE OF DEATH Month August Day 13 Year 1959		
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5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Dec 15, 1885	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher (Ret.)	10b. KIND OF BUSINESS OR INDUSTRY Meat Packing	11. BIRTHPLACE (City and state or country) Maysville, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Aaron Brown	13b. MOTHER'S MAIDEN NAME Caroline ?	14. NAME OF HUSBAND OR WIFE Lula Davis Brown
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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. 512-07-3849	17. INFORMANT Mrs Lula Brown, 703 Kentucky St., Elwood, Kans
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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:		INTERVAL BETWEEN ONSET AND DEATH One week
IMMEDIATE CAUSE (a) Transition + dehydration	DUE TO (b) Cerebrovascular occlusion - complete perf. 3 mos	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) of Q body & rt face & cranial base	
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 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.)
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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 _____
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21. I attended the deceased from 1957 to 8-12-59 and last saw him alive on 8-12-59 Death occurred at 7:10 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>E. Peterson, M.D.</i> (Degree or title)	22b. ADDRESS 3306 Mitchell Ave	22c. DATE SIGNED 8/15/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug 15, 1959	23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	23d. LOCATION (City, town, or county) St. Joseph, Missouri
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24. FUNERAL DIRECTOR Wm. H. Alexander, St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Aug. 17, 1959	26. REGISTRAR'S SIGNATURE <i>Miss. Clark Goodell</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION
E. Peterson, M.D.

BY AFFIDAVIT OF

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 Wm. H. Alexander

Licensed Embalmer No. 4450

P. O. Address St. Joseph

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.