

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032909

FILED VS OCT 2 1959 174

Registration District No. _____ Primary Registration District No. 3035 Registrar's No. 87

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>		Length of stay in 1b <u>6 Weeks</u>		c. CITY OR TOWN <u>Mayview</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lexington Memorial Hospt.</u>			Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>West side</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mahlon</u> Middle <u>Columbus</u> Last <u>Brannock</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>20,</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>June 20, 1875</u>	9. AGE (last birthday) <u>84</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>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (City and state or country) <u>Grayson, Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Pleasant C. Brannock</u>			13b. MOTHER'S MAIDEN NAME <u>Myra woods</u>		14. NAME OF HUSBAND OR WIFE <u>Lillie Louise Brannock</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>None</u>	17. INFORMANT Address <u>Mrs. M. C. Brannock, Mayview, 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>Carcinoma / stomach</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Inanition & Dehydration</u> DUE TO (c) <u>Semility</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Abdomen & liver filled with Carcinomatous mass</u> 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							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr 1 month</u>
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 _____ min. _____ 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>July 1959</u> to <u>Sept 20-59</u> and last saw her alive on <u>Sept 13-59</u> Death occurred at <u>14 A m 9/20/59</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>W Martin MD</u>				22b. ADDRESS <u>Odessa Mo</u>		22c. DATE SIGNED <u>9/21/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 22, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Odessa Cemetery</u>		23d. LOCATION (City, town, or county) <u>Odessa, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Husman-Sparks, Odessa, Mo.</u>			ADDRESS	25. DATE RECD. BY LOCAL REG. <u>9-25-59</u>	26. REGISTRAR'S SIGNATURE <u>Wm Heathwood</u>		

DOCUMENT

MEDICAL CERTIFICATION

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 William T. Sp...

Licensed Embalmer No. 44

P. O. Address Odessa

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.