

ENDED

1. PLACE OF DEATH a. COUNTY <u>Dade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dade</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Greenfield</u>		Length of stay in lb <u>40 yrs.</u>		c. CITY OR TOWN <u>Greenfield</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>407 Maple St.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>407 Maple St</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Payne</u> Middle <u>-</u> Last <u>Brand</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>6</u> Year <u>1959</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7-16-1900</u>		9. AGE (last birthday) <u>59</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>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Day labor</u>		11. BIRTHPLACE (City and state or country) <u>Lamar, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>						
13a. FATHER'S NAME <u>Amos Brand</u>				13b. MOTHER'S MAIDEN NAME <u>Jennie Payne</u>				14. NAME OF HUSBAND OR WIFE _____					
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 Name <u>Mrs. Blanche Sloan</u> Address <u>Greenfield, 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>Larynx - Tracheitis</u> DUE TO (b) <u>Acute tubercle Tuberculosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH			
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.)									
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>12-1-59</u> to <u>12-6-59</u> and last saw him alive on <u>12-6-59</u> Death occurred at <u>8:45</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Sh. O. Cowan MD</u> (Degree or title)						22b. ADDRESS <u>Greenfield, Mo.</u>			22c. DATE SIGNED <u>12/7/59</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 8, 1959</u>		23c. NAME OF CEMETERY OR CREMATORIA <u>Greenfield Cem. Greenfield, Mo.</u>				23d. LOCATION (City, town, or county) (State) <u>Greenfield, Mo.</u>					
24. FUNERAL DIRECTOR <u>J. C. Canada, Greenfield, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>12-7-1959</u>		26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NS DEC 17 1959

DEC 22 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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.