

**JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS DEC 28 1959** 274 Primary Registration District No. 3057 Registrar's No. 409 '59 0 4 4 9 4 8  
 STATE FILE NUMBER

UNDECEASED

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Moniteau</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia, Mo</u>		c. CITY OR TOWN <u>California, Mo</u>	
Length of stay in lb <u>5 Months</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>Home-304 S New York</u>		d. STREET ADDRESS (If outside, give location) <u>601 N Owen</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Amanda Lilianda Braun</u>			4. DATE OF DEATH Month Day Year <u>Dec 17 1959</u>		
---	--	--	---	--	--

5. SEX <u>Female</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>10/2/70</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>8</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
----------------------	-------------------------------	---	---------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Cwn Home</u>	11. BIRTHPLACE (City and state or country) <u>Cooper Co</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	---	---	---

13a. FATHER'S NAME <u>Charles W. Conas</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Vaughn</u>	14. NAME OF HUSBAND OR WIFE <u>Jim T. Braun</u>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Mrs. Lucian Samness S. Clarksville</u>
--	-------------------------------------	---

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
IMMEDIATE CAUSE (a)	<u>Myocardial Infarction</u>	<u>4 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral Hemorrhage</u>	<u>8 months</u>
	DUE TO (c) <u>Septicemia</u>	<u>4 years</u>

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 Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>8-7-59</u> to <u>12-17-59</u> and last saw her <u>live</u> on <u>12-17-59</u> Death occurred at <u>12/30</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>Woodmo Bldg, Sedalia</u>	22c. DATE SIGNED <u>12/19/59</u>
---	--	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/20/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Zion Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Bural - Clarksville, Mo</u>
---	---------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS <u>Bowlin Funeral Home - California, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-21-1959</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Earl Donahue*

Licensed Embalmer No. *212*

P. O. Address *Virginia*

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.